Filing at a Glance

Company:	Sun Life Assurance Company of Canada
Product Name:	2012 Critical Illness-Cancer Portability
State:	Arkansas
TOI:	H07G Group Health - Specified Disease - Limited Benefit
Sub-TOI:	H07G.001 Critical Illness
Filing Type:	Form
Date Submitted:	10/02/2012
SERFF Tr Num:	SNLF-128701171
SERFF Status:	Closed-Approved
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	2012 CRITICAL ILLNESS-CANCER PORTABILITY
Implementation Date Requested:	On Approval
Author(s):	Margaret Carvalho, Thomas Miele, Christopher McAuliffe, Pat Squillacioti, Marion Pagluica, Lori Chilcote, Pauline Michaud, Ellen Thibodeau, Linda Murphy, Stacy Amos
Reviewer(s):	Donna Lambert (primary)
Disposition Date:	12/03/2012
Disposition Status:	Approved
Implementation Date:	

State Filing Description:

General Information

Project Name: 2012 Critical Illness-Cancer Portability
Project Number: 2012 Critical Illness-Cancer Portability
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Discretionary
Filing Status Changed: 12/03/2012
State Status Changed: 12/03/2012
Created By: Christopher McAuliffe
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: These forms have been submitted to our domiciliary state of Michigan and are pending approval.
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Margaret Carvalho

Filing Description:
Sun Life Assurance Company of Canada
NAIC # 549-80802
FEIN # 38-1082080

RE: Forms Submitted for Approval
12-SDPort-C-01 - Group Critical Illness Insurance Certificate
GMPAP-2548 - Application

Dear Sir or Madam:

We submit the above referenced forms for your review and approval. These forms are new and do not replace any other forms previously approved by your Department. These forms are intended to comply with all applicable laws, rules, bulletins and published guidelines of your state. They are submitted in final print format, subject only to minor variations in color, paper stock, duplexing, shading, fonts and positioning.

These forms have been submitted to our domiciliary state of Michigan and are pending approval.

12-SDPort-C-01 - Group Critical Illness Insurance Certificate
This certificate will be used when an insured elects to port their remaining critical illness insurance provided by certificate form 12-SD-C-01, previously approved by your Department September 14, 2012 under SERFF number SNLF-128477205. It pays a lump-sum benefit payment to the insured upon diagnosis of a covered condition specified in the certificate.

This certificate will be issued in connection with a group insurance policy issued to an out-of-state trust situsued in Rhode Island.

GMPAP-2548 - Application
We will use this new application to initially offer the enclosed new group critical illness insurance certificate.

The enclosed forms include brackets around the items that may vary. The bracketed items shown are the hypothetical values for the representative sample provided. The use of variability in the enclosed forms will be administered as described in the enclosed statements of variable material and in a uniform manner.

State: *Arkansas* **Filing Company:** *Sun Life Assurance Company of Canada*
TOI/Sub-TOI: *H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*
Product Name: *2012 Critical Illness-Cancer Portability*
Project Name/Number: *2012 Critical Illness-Cancer Portability/2012 Critical Illness-Cancer Portability*

Please do not hesitate to contact me if you have any questions regarding this submission. Thank you for your attention to this matter.

Company and Contact

Filing Contact Information

Margaret Carvalho, Compliance Consultant Margaret.Carvalho@sunlife.com
175 Addison Road 860-737-1278 [Phone] 1278 [Ext]
W455 860-737-6598 [FAX]
Windsor, CT 06095

Filing Company Information

Sun Life Assurance Company of Canada
175 Addison Road
Windsor, CT 06095
(860) 737-1000 ext. [Phone]

CoCode: 80802
Group Code: 549
Group Name:
FEIN Number: 38-1082080

State of Domicile: Michigan
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	2 x 50.00 = $100.00
Per Company:	No

Company	Amount	Date Processed	Transaction #
Sun Life Assurance Company of Canada	$100.00	10/02/2012	63330238

SERFF Tracking #:	*SNLF-128701171*	***State Tracking #:***		***Company Tracking #:***	*2012 CRITICAL ILLNESS-CANCER PORTABILITY*

State:	*Arkansas*	***Filing Company:***	*Sun Life Assurance Company of Canada*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*2012 Critical Illness-Cancer Portability*		
Project Name/Number:	*2012 Critical Illness-Cancer Portability/2012 Critical Illness-Cancer Portability*		

Form Schedule

Lead Form Number: 12-SDPort-C-01

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 12/03/2012	Critical Illness/Cancer Portability Certificate	12-SDPort-C-01	CER	Initial		50.500	12-SDPort-C-01 - AR - Critical Illness Portability 11-14-12.pdf
2	Approved 12/03/2012	Portability Application	GMPAP-2548	AEF	Initial		50.100	GMPAP-2548 - Portability Application - 11-2-12.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
[One Sun Life Executive Park]
[Wellesley Hills, MA 02481]

[(800) 247-6875]
[www.sunlife.com/us]

Sun Life Assurance Company of Canada certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

Policy Number:	[00000001]
Policy Effective Date:	[September 1, 2012]
Policyholder:	[ABC Trust]
Certificate Number:	[12345]
Certificate Effective Date:	[September 1, 2012]
Issue State:	[Massachusetts]

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

This Certificate contains the terms of the Group Insurance Policy that affect your insurance. This Certificate is part of the Group Insurance Policy.

This Certificate is governed by the laws of the Issue State shown above.

Signed at Wellesley Hills, Massachusetts.

[Dean A. Connor]
[President and Chief Executive Officer]

[Dana J. Easthope]
[Vice-President, Associate General Counsel and Corporate Secretary]

Group Critical Illness Insurance Certificate
[Critical Illness and Cancer]

Non-Participating

Sun
[Life Financial℠]

NOTICE TO CERTIFICATEHOLDER

THIS NOTICE IS TO ADVISE YOU THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING YOUR SUNLIFE GROUP INSURANCE PLAN, YOU MAY CONTACT THE FOLLOWING:

SUN LIFE ASSURANCE COMPANY OF CANADA
[GROUP CUSTOMER SERVICE CENTER SC1219
U.S. HEADQUARTERS OFFICE
ONE SUN LIFE EXECUTIVE PARK
WELLESLEY HILLS, MA 02481
(800) 247-6875

ALSO AVAILABLE TO YOU IS THE CONSUMER SERVICES DIVISION OF THE ARKANSAS INSURANCE DEPARTMENT, [1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS 72201-1904, (501) 371-2640 or (800) 852-5494]

TABLE OF CONTENTS

1. BENEFIT HIGHLIGHTS

Participant: **John Doe**

[Premium Due Date: [The first day of each month] **]**

Insurance Amounts

[Participant Insurance Amount:	[$100,000] [Change Increment Amount: [$5,000]] Minimum: [$5,000]
Insured: [John Doe] **]**	
[Spouse Insurance Amount:	[$100,000] [Change Increment Amount: [$5,000]] Minimum: [$5,000]
Insured: [Jane Doe] **]**	
[Dependent Children Insurance:	[Change Increment Amount: [$5,000]] Minimum: [$5,000]
Insured: [Bill Doe]	[$100,000]
[Insured: [Bob Doe]]	[$100,000] **]**

[Circulatory Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Heart Attack	[100%]]
[Stroke	[100%]]
[Heart Transplant	[100%]]
[Coronary Artery Bypass Surgery	[25%]]
[Aortic Surgery	[25%]]
[Coronary Artery Angioplasty	[25%]] **]**

[Cancer Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Cancer	[100%]]
[Non-Life Threatening Cancer	[25%]] **]**

[Other Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Benign Brain Tumor	[100%]]
[Coma	[100%]]
[Major Organ Failure	[100%]]
[Paralysis	[100%]]
[Severe Burns	[100%]] **]**

[Childhood Conditions Category - [Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Cerebral Palsy	[100%]]
[Congenital Heart Disease	[100%]]
[Cystic Fibrosis	[100%]]
[Type 1 Diabetes Mellitus	[100%]]
[Muscular Dystrophy	[100%]] **]**

Maximum Benefits Payable for each Insured under this Certificate:

- We will only pay one benefit for each Covered Condition shown above;
- We will not pay more than an aggregate of [100%] of the benefit payable for Covered Conditions in the same Category**[**; and
- We will not pay more than an aggregate of [200%] of the benefit payable for all the Covered Conditions in all Categories shown above].

Note: All benefits available for Covered Conditions under this portability Certificate will be reduced by any benefits paid or payable under the Qualifying Group Insurance Policy. The Maximum Benefits available under this Certificate shall be reduced by any benefits paid or payable under the Qualifying Group Insurance Certificate.

2. DEFINITIONS

Benefit Percentage means the percentage that is applied to your Insurance Amount to determine the amount of Critical Illness benefits payable under the Policy.

[**Clinical Diagnosis** means a Diagnosis of Cancer based on observation and history, diagnostic and laboratory studies, and symptoms.]

Critical Illness means only the illnesses [or procedures] defined in the Covered Conditions section of this Certificate for which benefits are payable.

[Dependent Child means the Participant's:

- [[unmarried] child from live birth to under age [26] [who is enrolled as a full time student and depends on the Participant for [50%] or more of the child's support.]]

Dependent Child includes:

- **[**a Participant's [unmarried] step-child];
- [a child for whom the Participant has legal guardianship];
- [a foster child placed with the Participant by a licensed agency];
- a Participant's adopted child, including any child placed with the Participant for adoption;

[If [an] [unmarried] child is age [26] or older and is:

- **[**incapable of self-sustaining employment because of a mental retardation, developmental disability or physical handicap]; [and
- dependent on the Participant for **[**[50%] or more of his/her**]** support;**]**

that child will continue to be a Dependent under the Policy for as long as these conditions exist.**]**

[No person may be considered to be a Dependent Child of more than one Participant.]

Dependent Child does not include:

- **[**any person who is insured as a Participant; or]
- any person residing outside the [United States], [Canada], or [Mexico]. [This exclusion does not apply to a Dependent Child who resides with a Participant who is on a temporary work assignment outside the [United States].**]**

Diagnosis (Diagnosed) means a definitive identification of the Critical Illness made during the lifetime of the Insured by a Specialist Physician:

- supported by documentation of all appropriate and defined studies;
- based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
- meeting any diagnostic requirements stated in this Certificate for the particular Critical Illness being diagnosed.

[**Divorce** means the dissolution of any relationship identified in the Marriage definition and the term "divorce decree" means the court-issued document appropriate for the termination of such a relationship.]

Insurance Amount means the amount of insurance available under the Policy as shown in the Benefit Highlights and for which a person covered under the Policy is insured.

Insured means any person covered under the Policy as named in the Benefit Highlights.

[Marriage means any of the following relationships recognized under applicable state law: a same-sex or opposite-sex marriage; a civil union partnership under which the partners have the same legal rights and

responsibilities as a married couple; [and a same-sex or opposite-sex registered domestic partnership under which the partners have the same legal rights and responsibilities as a married couple.]**]**

Participant means a person who was insured under a Qualifying Group Insurance Policy and who applied for insurance under the Policy. The Participant eligible for insurance under this Certificate is shown in the Benefit Highlights.

Physician means an individual who is operating within the scope of his or her license and is either:

- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

The Physician cannot be you, a business associate or any family member. “Family member” means: (a) your spouse and (b) the following relatives of you or your spouse: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Policy means the group insurance policy under which this Certificate is issued.

Proof means any medical, financial, or other information that is required under by us and is satisfactory to us.

Qualifying Group Insurance Policy means the group insurance policy we issued which included the portability option to apply for insurance under the Policy.

Specialist Physician means a medical doctor who is licensed and practicing in the United States or Canada and who has completed an accredited specialty training program recognized by the American Board of Medical Specialties and has passed the examination leading to Board Certification in the field most applicable to the condition being evaluated or equivalent certification acceptable to us.

[Spouse means any individual who under applicable state law is either recognized as a spouse, partner to a civil union[, a partner to a registered domestic partnership] under which the partners have the same legal rights and responsibilities as a married couple, or are otherwise accorded the same rights as a spouse.

Spouse does not include any person residing outside the [United States], [Canada], or [Mexico]. [This exclusion does not apply to a Spouse who resides with a Participant who is on a temporary work assignment outside the [United States].] **]**

Treatment means a Physician's consultation, care or services; diagnostic measures; or the prescription, refill or taking of prescribed drugs or medicines.

We, Us, Our (we, us, our) means Sun Life Assurance Company of Canada.

You, Your (you, your) means the Participant who is eligible for insurance under this Certificate.

3. PORTABILITY

When are you eligible for portability insurance?
You are eligible under the Qualifying Group Insurance Policy to elect to continue your insurance for up to [60 months] if all of the following requirements are met:

- [you have been validly Insured under the Qualifying Group Insurance Policy for at least [36 consecutive months];]
- your insurance ends because you terminate employment for reasons other than [leave of absence, labor strike, retirement, sickness or injury];
- the Qualifying Group Insurance Policy is still in force;
- you reside in the United States [or Canada];
- [you have not exercised your portability right under a similar certificate issued by us;] and
- you are under age [70] at the time employment terminates.

Your new portability insurance is provided by this Certificate. Your new portability insurance may not be identical to your current insurance under the Qualifying Group Insurance Policy.

What is the amount of portable insurance?
You may apply for portable insurance in an amount up to [100%] of each Insured's remaining amount of insurance validly in force under the Qualifying Group Insurance Policy on the date your insurance terminates. In no instance will the insurance issued under this Certificate be greater than the remaining amount of insurance in force under the Qualifying Group Insurance Policy on the date such insurance terminates. Your new portability insurance policy will not provide any benefits beyond those described in this Certificate.

When does your portable insurance start?
After your insurance under the Qualifying Group Insurance Policy terminates, your portable insurance provided by this Certificate starts on the later of the following:

- the date we approve your application for portable insurance; and
- the date we receive your first premium payment for portable insurance.

[When is portability available to the Spouse and when is the Spouse eligible?
Portability is available for the Spouse under the Qualifying Group Insurance Policy for up to [60 months] if all of the following requirements are met:

- the employee under the Qualifying Group Insurance Policy [dies] [or Divorces their Spouse];
- **[**the employee under the Qualifying Group Insurance Policy had been Insured under the Policy for at least [36 consecutive months];**]**
- the Qualifying Group Insurance Policy is still in force;
- the Spouse resides in the United States [or Canada]; and
- the Spouse is under age [70] at the time of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy.

The Spouse's new portability insurance is provided by this Certificate. Their new portability insurance may not be identical to the insurance under the Qualifying Group Insurance Policy.

What is the amount of the Spouse's portable insurance?
The Spouse may apply for portable insurance in an amount up to [100%] of the remaining amount of [Spouse Insurance] [and Dependent Children Insurance] in force under the Qualifying Group Insurance Policy on the date of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy. In no instance will the [Spouse Insurance] [and Dependent Children Insurance] issued under this Certificate be greater than the remaining amount of [Spouse Insurance] [and Dependent Children Insurance] in force under the Qualifying Group Insurance Policy on the date of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy. The Spouse's new portability insurance policy will not provide any benefits beyond those described in this Certificate.

[The Spouse may not apply for portable insurance for a Dependent Child whose insurance has not terminated under the Qualifying Group Insurance Policy due to Divorce.]

When does the Spouse's portable insurance start?
After the [Death] [or Divorce] of the employee under the Qualifying Group Insurance Policy, the Spouse's portable insurance will start on the later of the following:

- the date we approve the Spouse's application for portable insurance; and
- the date we receive the Spouse's first premium payment for portable insurance.**]**

4. EFFECTIVE DATES AND TERMINATION OF PARTICIPANT INSURANCE

When does Participant Insurance start?
Participant Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

How can you make changes in Participant Insurance?
You may request a decrease in your Participant Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease your Participant Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Participant Insurance start?
Any reduction in your Participant Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Participant Insurance end?
Your Participant Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- [the date you attain age [70];]
- the last day for which any required premium has been paid for your Participant Insurance;
- the date you request in writing to end your Participant Insurance;
- [the date you reside outside the United States [or Canada;]
- [the date you become insured again under the Qualifying Group Insurance Policy;] or
- the date all benefits paid for you under the Policy reach the maximum amount payable as described herein.

[5. EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When does Spouse Insurance start?
Spouse Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

How can you make changes in Spouse Insurance?
You may request a decrease in your Spouse Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease the Spouse Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Spouse Insurance start?
Any reduction in your Spouse Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Spouse Insurance end?
Your Spouse Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- [the date your Spouse attains age [70];]
- the last day for which any required premium has been paid for your Spouse Insurance;
- the date you request in writing to end your Spouse Insurance;
- the date you reside outside the United States [or Canada];
- [the date you become insured again under the Qualifying Group Insurance Policy];
- the date all benefits paid for your Spouse under the Policy reach the maximum amount payable for your Spouse as described herein; and
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate.**]**

[[6.] EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

When does Dependent Children Insurance start?
Dependent Children Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

[How can you make changes in Dependent Children Insurance?
You may request a decrease in your Dependent Children Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease the Dependent Children Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Dependent Children Insurance start?
Any reduction in your Dependent Children Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Dependent Children Insurance end?
Your Dependent Children Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- the last day for which any required premium has been paid for your Dependent Children Insurance;
- the date you request in writing to end your Dependent Children Insurance;
- the date all benefits paid for you under the Policy reach the maximum amount payable as described herein;
- the date you reside outside the United States [or Canada];
- [the date you become insured again under the Qualifying Group Insurance Policy];
- for a specific Dependent Child, the date all benefits paid reach the maximum amount payable as described herein; and
- the date a Dependent Child no longer meets the definition of Dependent Child as described in this Certificate.**]**

[7.] PREMIUMS

When are your premiums due and how are they determined?
Your first premium is due on the Certificate Effective Date. Subsequent premiums are due on the Premium Due Date. Premiums are based upon the then current premium rates in effect for the benefits provided.

Premiums are payable to us at [our Executive Office] and will be paid in United States dollars [and Canadian dollars] [and Canadian dollars at the accepted daily rate of exchange], on the Premium Due Date.

Can premium rates that apply to your insurance change?
We determine initial and any subsequent premium rates. [We have the right to recalculate any premium rate after the initial premium rate has been in effect for [12 months].]

We will provide you written notice of any change in the premium rates at least [60] days prior to the effective date of the change.

What is the grace period?
The grace period is the [31-day] period of time following the Premium Due Date during which you may make an unpaid premium payment. If you do not pay the required premium before the end of the grace period, this Certificate will automatically terminate at the end of the grace period. Should any benefits become payable as a result of insurance provided during the grace period, we may deduct any premiums due from those benefits.

[8.] BENEFIT PROVISIONS

What benefits are payable?
We will pay you a lump-sum benefit for the insurance in force each time any eligible Insured, on or after the Certificate Effective Date:

- is Diagnosed with a Critical Illness condition[; or
- undergoes a Critical Illness procedure,]

as defined in the Covered Conditions section of this Certificate.

Any benefits payable are subject to the limitations, exclusions and other conditions stated in this Certificate.

How is the amount of the benefit determined?
We will multiply the Insured's Insurance Amount by the Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

[9.] COVERED CONDITIONS

What Critical Illness conditions are covered?
The Critical Illness conditions [and procedures] listed below are covered under the Policy.

[CIRCULATORY CONDITIONS CATEGORY

[**Heart Attack** means a confirmed Diagnosis of the death of heart muscle due to acute obstruction of a coronary artery that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction and includes at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a Heart Attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist Physician.

Exclusions:
Heart Attack does not include:
- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- silent myocardial infarction, including ECG or imaging changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.]

[Stroke (cerebrovascular accident) means a confirmed Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or cerebral embolism from an extra-cranial source, with:
- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination which persist for [30 days] following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The Diagnosis of Stroke must be made by a Specialist Physician.

Exclusions:
Stroke does not include any of the following:
- transient ischemic attacks;
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.**]**

[Heart Transplant means a confirmed Diagnosis of the irreversible failure of the heart and that transplant is medically necessary as soon as an appropriate donor is located. Heart Transplant under the Policy includes a procedure to replace the heart together with a lung, commonly referred to as a heart/lung transplant. To qualify under Heart Transplant, the Insured must be listed with the United Network of Organ Sharing (UNOS) on a Heart Transplant waiting list or have undergone a Heart Transplant as the recipient while insured under the Policy. The Diagnosis of the heart failure requiring Heart Transplant must be made by a Specialist Physician.]

[**Coronary Artery Bypass Surgery** means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-

catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a Specialist Physician.]

[**Aortic Surgery** means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist Physician.]

[**Coronary Artery Angioplasty** means the undergoing of balloon angioplasty, laser angioplasty, or atherectomy or the placement of a stent to correct narrowing or blockage of one or more coronary arteries. The Coronary Artery Angioplasty must be determined to be medically necessary by a Specialist Physician.]**]**

[CANCER CONDITIONS CATEGORY

Cancer means a confirmed Diagnosis of a tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist Physician.

A Clinical Diagnosis will be accepted only if:

- a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
- there is medical evidence to support the Diagnosis; and
- a Physician is treating you for Cancer.

In all other cases, Cancer must be Diagnosed with histopathological confirmation.

Exclusions:
Cancer does not include:

- carcinoma in situ;
- evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including, but not limited to, proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis; or
- any non-melanoma skin cancer that has not become metastasized.

No benefit will be payable under this provision for the Non-Life Threatening Cancers listed in the Non-Life Threatening Cancer provision below.

[No benefit will be payable for a recurrence or metastasis of an original Cancer which was Diagnosed prior to the effective date of insurance.]

[*Cancer Benefit Waiting Period:*
No benefit will be payable for Cancer and the Insured's insurance for Cancer and Non-Life Threatening Cancer will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the Insured's insurance; and
- the effective date of the Insured's insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of any cancer (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of any cancer (covered or excluded under this insurance).

Although the Insured's insurance for Cancer and Non-Life Threatening Cancer terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Cancer or Non-Life Threatening Cancer or any Critical Illness caused by any cancer or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Cancer Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Cancer Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Cancer Benefit Waiting Period. **]**

Non-Life Threatening Cancer is limited to the following:

- chronic lymphocytic leukemia that has not progressed beyond Rai stage 0;
- Stage 1A (T1a) malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion);
- Stage A (T1a or T1b) prostate cancer;
- papillary microcarcinoma of the thyroid, which for the purposes of the Policy means a papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid;
- noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0; and
- ductal carcinoma in situ (DCIS)of the breast.

Non-Life Threatening Cancer must be Diagnosed by a Specialist Physician with histopathological confirmation.

Exclusions:

Non-Life Threatening Cancer does not include any of the following:

- pre-malignant lesions;
- any carcinoma in situ except ductal carcinoma in-situ of the breast;
- evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

[No benefit will be payable for a recurrence or metastasis of an original Non-Life Threatening Cancer which was Diagnosed prior to the effective date of insurance.]

[*Non-Life Threatening Cancer Benefit Waiting Period:*

No benefit will be payable for Cancer and Non-Life Threatening Cancer and the Insured's insurance for Cancer and Non-Life Threatening Cancer will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the Insured's insurance; and
- the effective date of the Insured's insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of any cancer (covered or excluded under this insurance), regardless of when the Diagnosis is made; or
b. a Diagnosis of any cancer (covered or excluded under this insurance).

Although the Insured's insurance for Cancer or Non-Life Threatening Cancer terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Cancer or Non-Life Threatening Cancer or any Critical Illness caused by any cancer or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Non-Life Threatening Cancer Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Non-Life Threatening Cancer Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Non-Life Threatening Cancer Benefit Waiting Period.**]]**

[OTHER CONDITIONS CATEGORY

[Benign Brain Tumor means a confirmed Diagnosis of a non-malignant tumor located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumor must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumor must be made by a Specialist Physician.

Exclusions:
Benign Brain Tumor does not include pituitary adenomas less than 10 mm. in diameter.

[No benefit will be payable for a recurrence or metastasis of an original tumor which was diagnosed prior to the effective date of insurance.]

[*Benign Brain Tumor Benefit Waiting Period:*
No benefit will be payable for Benign Brain Tumor and the Insured's insurance for Benign Brain Tumor will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the person's insurance; and
- the effective date of the person's insurance,

the Insured has any of the following:
a. signs, symptoms or investigations, that lead to Diagnosis of Benign Brain Tumor (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of Benign Brain Tumor (covered or excluded under this insurance).

Although the Insured's insurance for Benign Brain Tumor terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Benign Brain Tumor or any Critical Illness caused by Benign Brain Tumor or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Benign Brain Tumor Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Benign Brain Tumor Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Benign Brain Tumor Benefit Waiting Period.**]]**

[**Coma** means a confirmed Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The Diagnosis of coma must be made by a Specialist Physician.

Exclusions:
Coma does not include any of the following:
- a medically induced coma; or
- a coma which results directly from alcohol or drug use.]

[**Major Organ Failure** means a confirmed Diagnosis by a Specialist Physician of the irreversible end-stage failure of bone marrow, kidney, liver or lung function, and:

- [for kidney failure only, dialysis (either hemo or peritoneal) is initiated;] or
- for all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Insured
  - is either listed with the United Network of Organ Sharing (UNOS); or
  - a suitable donor is found without a UNOS listing.

Proof of Major Organ Failure requires:

- submission of medical records documenting major organ failure from a Specialist Physician; and
- except for kidney failure on dialysis, documentation of either a
  - listing with the United Network of Organ Sharing (UNOS); or
  - documentation that a suitable donor has been found without a UNOS listing.

Major Organ Failure will be deemed to have occurred:

- [for kidney failure only, the date either dialysis is initiated,] or
- for all organs listed above, the date that the Insured
  - is either listed with the United Network of Organ Sharing (UNOS); or
  - a suitable donor is found without a UNOS listing.

Exclusions:
Major Organ Failure does not include any of the following:
- bone marrow failure that results from the treatment process for cancer;
- failure of any other organ not listed above; and
- autologous bone marrow transplant in which the Insured's own bone marrow is used.]

[**Paralysis** for the purposes of the Policy means total and irrecoverable loss of function of two or more limbs as a result of injury to or disease of the spinal cord. The loss must be present for a continuous period of at least [90 days] and be expected to be permanent. Limb is defined as the complete arm or the complete leg. The Diagnosis of paralysis must be made by a Specialist Physician.]

[**Severe Burns** means a confirmed Diagnosis of third-degree burns over at least 20% of the body surface. Severe Burns must occur while the Insured's insurance is in force to be eligible for a benefit. The Diagnosis of Severe Burns must be made by a Specialist Physician.]**]**

[CHILDHOOD CONDITIONS CATEGORY
The following covered childhood conditions apply only to children who meet the definition of Dependent Children and are insured under this Certificate:

[**Cerebral Palsy** means a confirmed Diagnosis of nonprogressive, neurological defect affecting muscle control. Diagnosis for Cerebral Palsy must be made by a Specialist Physician.]

[**Congenital Heart Disease** means a confirmed Diagnosis of at least one of the following covered heart conditions:

- coarctation of the aorta;
- Ebstein's anomaly;
- Eisenmenger syndrome;
- Tetralogy of Fallot;
- transposition of the great vessels; or
- any other congenital cardiac condition that requires life-saving surgery to survive.

It also means any one of the following specific conditions for which open heart surgery is performed to correct:

- aortic stenosis;
- atrial septal defect;
- discrete subvalvular aortic stenosis;
- pulmonary stenosis; or
- ventricular septal defect.

Exclusions:
Congenital Heart Disease does not include any of the following procedures:

- percutaneous atrial septal defect closure; or
- trans-catheter procedures which include balloon valvuloplasty.

The Diagnosis of Congenital Heart Disease must be made and the surgery must be recommended and performed by a Specialist Physician and supported by cardiac imaging acceptable to us.]

[**Cystic Fibrosis,** also known as mucoviscidosis, means the confirmed Diagnosis of a recessive genetic disease affecting most critically the lungs and also the pancreas, liver, and intestine. It is characterized by abnormal transport of chloride and sodium across the epithelium leading to thick viscous secretions. The Diagnosis of cystic fibrosis must be made by a Specialist Physician.]

[**Type 1 Diabetes Mellitus** means a confirmed Diagnosis where the Insured has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months. The Diagnosis of type 1 diabetes mellitus must be made by a Specialist Physician.]

[**Muscular Dystrophy** means a confirmed Diagnosis of one of a group of muscle diseases characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue. The confirmed Diagnosis of Muscular Dystrophy must be made by a Specialist Physician.]

[*Childhood Conditions Benefit Waiting Period:*
No benefit will be payable for any Childhood Condition and the Insured's insurance for such Childhood Condition will terminate if, within [30 days] following the effective date of the Dependent Child's insurance, the Dependent Child has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of such Childhood Condition (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of such Childhood Condition (covered or excluded under this insurance).

Although the Insured's insurance for such Childhood Condition terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for a Childhood Condition or any Critical Illness caused by a Childhood Condition or its Treatment.

The Childhood Conditions Benefit Waiting Period does not apply when newborn or newly adopted children are added to your Dependent Children Insurance.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Childhood Conditions Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Childhood Conditions Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Childhood Conditions Benefit Waiting Period.**]]**

[10.] LIMITATIONS AND EXCLUSIONS

What exclusions apply to the benefits payable?
In addition to the exclusions stated in the Covered Conditions section of this Certificate, we will not pay any benefit that is caused by, contributed to in any way, or resulting from any of the following:

- any Critical Illness condition Diagnosed outside the United States or Canada without confirmation of the Diagnosis by the type of Specialist Physician specified for each of the Covered Conditions in Section [9] who practices in the United States or Canada[; or
- any Critical Illness procedure performed outside the United States or Canada].

We will not pay a benefit for any Critical Illness that is due to or results from:

- intentionally self-inflicted injuries;
- elective plastic or cosmetic surgery;
- active military duty;
- participation in war, declared or undeclared, or any act of war;
- [active participation in a riot, rebellion or insurrection;]
- [committing or attempting to commit an assault, felony or other criminal act;]
- [engagement in scuba diving, parachuting, hang gliding, motorized racing, ballooning, kick-boxing, cliff diving, mountain climbing, powerboat racing, heli-skiing, big game hunting, cave exploration, extreme sports, underwater diving, rodeo events or white water rafting, where there is a likelihood of death or serious injury;]
- [being legally intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed; or]
- [improper or illegal use of inhalants or huffing].

What limitations apply to the benefits payable?
In addition to the limitations stated in the Covered Conditions section of this Certificate, we will not pay any benefit for any Critical Illness that is Diagnosed in the first [12 months] following the effective date of any Insured's insurance and results from a Pre-Existing Condition.

Pre-Existing Condition means during the [6 months] prior to any Insured's effective date of insurance, any condition for which any Insured:

- sought medical treatment, consultation, advice, care or services, including diagnostic measures for the condition, regardless of whether the condition was diagnosed or suspected at that time;
- took prescribed drugs or medicines for the condition[; or
- had symptoms for which an ordinarily prudent person would have consulted a health care provider for Diagnosis, care or Treatment].

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Pre-Existing Condition limitation toward the satisfaction of the period of time required by this Certificate's Pre-Existing Condition limitation.

What are the maximum benefits payable under this Certificate?
[We will only pay one benefit for each Covered Condition shown in the Benefit Highlights.] We will not pay more than an aggregate of [100%] of the benefits payable for all Covered Conditions in the same Category as shown in the Benefit Highlights. [We will not pay more than an aggregate of [200%] of the benefits payable for all the Covered Conditions in all Categories shown in the Benefit Highlights.]

[11.] CLAIMS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us written Notice and Proof of claim within the time limits specified.

NOTICE OF CLAIM

When does written Notice of Claim have to be submitted?
Written notice of claim must be given to us no later than [60 days] after the date of Diagnosis or within [90 days] of the Treatment of the Critical Illness.

If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

When we receive written notice of claim, we will send the forms for Proof of claim. If the forms are not received within 15 days after written notice of claim is sent, Proof of claim may be sent to us without waiting to receive the Proof of claim forms.

PROOF OF CLAIM

When does written Proof of claim have to be submitted?
Proof of claim must be given to us no later than [120 days] after the date of Diagnosis or Treatment of the Critical Illness.

If Proof cannot be given within these time limits, Proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time Proof is otherwise required unless the individual is legally incompetent.

What is considered Proof of claim?
Proof of claim must consist of at least the following information:

- a description of the Critical Illness;
- the date the Diagnosis and/or Treatment occurred; and
- the cause of the Critical Illness.

Proof of claim may include, but is not limited to, police accident reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials, as required.

We may require as part of the Proof, authorizations to obtain medical and non-medical information. Proof must be satisfactory to us.

PAYMENT OF BENEFITS

When are benefits payable?
Benefits are payable upon our receipt of satisfactory Proof of claim that establishes benefit eligibility according to the provisions of this Certificate.

When will a decision on your claim be made?
We will send you a written notice of our decision on your claim within a reasonable time after we receive the claim but not later than [45 days] after receipt of the claim. If we cannot make a decision within [45 days] after receiving your claim, we will request a [30-day] extension as permitted by U.S. Department of

Labor regulations. If we cannot render a decision within the extension period, we will request an additional [30-day] extension. Any request for extension will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have [45 days] to provide the specified information.

What if your claim is denied?
If we deny all or any part of your claim, you will receive a written notice of denial setting forth:

- the specific reason(s) for the denial;
- the specific Certificate provision(s) on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- [your right to bring a civil action under ERISA, §502(a) following an adverse determination on review.]
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

Can you request a review of a claim denial?
If all or part of your claim is denied, you may request in writing a review of the denial within [180 days] after receiving notice of denial.

You may submit written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

We will review the claim on receipt of the written request for review, and will notify you of our decision within a reasonable time but not later than [45 days] after the request has been received. If an extension of time is required to process the claim, we will notify you in writing of the special circumstances requiring the extension and the date by which we expect to make a determination on review. The extension cannot exceed a period of [45 days] from the end of the initial period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have at least [45 days] to provide the specified information.

What if your claim is denied on review?
If we deny all or any part of your claim on review, you will receive a written notice of denial setting forth:

- the specific reasons for the denial;
- the specific Certificate provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- [your right to bring a civil action under ERISA, §502(a);]

- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request;
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency."; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the appeal, regardless of whether the advice was relied upon to deny the appeal.

To whom are benefits payable?
We will pay you all benefits, if your Proof of claim is satisfactory to us, except in the following situations:

1. You are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons;
2. Due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described in item 1; or
3. You die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay to such person or persons.

If we do not pay you and claim is not made by the appropriate person designated above, we may make payments under either or both Methods A or B below. We may decide to pay any benefits, prior to the appointment of the appropriate person designated in items [1, 2, or 3 above], and/or we may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

Method A: We may pay up to the sum of [$5,000] to any individual or entity that has provided Proof of having incurred or paid expenses as a result of funeral services provided to or on your behalf. If we pay such a benefit, we will not have to pay that benefit amount again and the total benefit due under this Certificate shall be reduced by the amount paid under this provision.

Method B: We may pay the whole or any part of such benefit:
- to your lawful spouse, up to a cumulative amount of [$5,000]; or
- if you have no lawful spouse, up to a cumulative amount of [$5,000] to any one or more of the following relatives in the following order of priority:

    1. your child or children; or
    2. your mother or father.

[12.] GENERAL PROVISIONS

ALTERATION

Who can alter this Certificate?
The only persons with the authority to alter or modify this Certificate or to waive any of its provisions are our president, actuary, secretary or one of our vice presidents and any such changes must be in writing.

[ASSIGNMENT

Can benefits be assigned?
You cannot assign any interest in this Certificate unless we agree in writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by us will discharge our liabilities under this Certificate, to the extent of such payments.]

CLERICAL ERROR

What happens when there is a clerical error in the administration of this Certificate**?**
Clerical errors in connection with this Certificate or delays in keeping records for this Certificate whether by us or the Policyholder:

- will not terminate insurance that would otherwise have been effective.
- will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error, subject to the "Limit of Premium Refunds" section.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of this Certificate conflicts with any applicable law, the provisions of this Certificate will be automatically amended to meet the minimum requirements of the law and to reflect updated statutory references.

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under this Certificate?
Payment made under the terms of this Certificate will, to the extent of such payment, release us from all further obligations under this Certificate. We will not be obligated to see to the application of such payment.

EXAMINATION

What are our examination rights?
We, at our own expense, have the right to have any person whose Critical Illness is the basis of a claim:

- examined by a Physician, Specialist Physician, other health professional or vocational expert of our choice; and/or

- interviewed by an authorized representative.

This right may be used as often as reasonably required.

INCONTESTABILITY

What is Incontestability?
Except for non-payment of premium, any claims incurred within two years of the effective date of an Insured's initial or reinstated insurance or as otherwise stated in this provision, we cannot contest the validity of such insurance regarding any Insured after it has been in force during the lifetime of such Insured for a period of two years from the Certificate Effective Date.

Additionally, for any insurance provided under the Policy that results from a statement of insurability submitted under the Qualifying Group Insurance Policy, except for any claims incurred before that insurance has been in force under the Qualifying Group Insurance Policy and this Policy for an aggregate period of two years during the insured's lifetime, measured from the effective date of the insurance for which the statement was provided, we cannot contest the validity of such insurance based on that statement.

This provision shall not preclude the assertion at any time of a defense to a claim based upon the Insured's eligibility for insurance.

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of this Certificate?
If relevant facts about the Participant relating to this insurance are not accurate:

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the true facts will decide whether, and in what amount, and for what duration insurance is valid under this Certificate.

NON-PARTICIPATING

Does this Certificate participate in dividends?
This Certificate is non-participating and will not share in any profits or surplus earnings of Sun Life Assurance Company of Canada, and, therefore, no dividends are payable.

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?
No legal action may start:

- until [60 days] after Proof has been given; nor
- more than [3 years] after the time Proof of claim is required.

LIMIT OF PREMIUM REFUNDS

Is there a limit on premium refunds?
Whether premiums were paid in error or otherwise, we will refund only that part of the excess premium that was paid during the [12-month] period that preceded the date we learned of such overpayment.

NOTICE

How are required notices provided?
Any obligation we may have to give written notice will be satisfied by sending such notice to the last known address of the person or institution entitled to such notice.

PREMIUM PAYMENTS AS EVIDENCE OF INSURANCE

Does the payment of premiums guarantee coverage under the Policy?
The receipt of premiums by us is not a guarantee of insurance. Eligibility for benefits will be determined at the time of claim submission and all Policy requirements must be satisfied.

REIMBURSEMENT

What if a benefit is underpaid or overpaid?
Reimbursement will be made to us for any overpayments that we may make due to any reason. You must repay us within 60 days unless we agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If we have underpaid a benefit for any reason, we will make a lump sum payment for that amount.

Interest does not accrue on any underpaid or overpaid benefit unless required under the applicable law.

STATEMENTS

Are statements warranties?
In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by you in enrolling for insurance under the Policy will be used to reduce or deny a claim unless a copy of your written application for insurance is or has been given to you, your beneficiary, if any, or to your estate representative.

TIME PERIODS

What time periods apply to this Certificate?
For the purpose of effective dates and termination dates under this Certificate, all days begin at 12:00 midnight and end at 11:59:59 PM at the Participant's location.

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Critical Illness Insurance Certificate
[Critical Illness and Cancer]

Non-Participating

Sun Life Assurance Company of Canada

Portability Application – [Disability] [and] [Critical Illness]

Please complete the sections indicated below, read the fraud warnings and acknowledgement, and sign and date the form. Mail the completed form, a copy of your Portability Notice, and a check for the first premium to Sun Life Assurance Company of Canada. Questions about portability? Please call 1-800-247-6875.

I am applying for Portable:

[☐ Disability insurance (complete sections 1, [2.1], 3 and 5)]

[☐ Critical Illness insurance (complete sections 1, [2.2], 3 and 5)]

1 General information

Your name (first, middle initial, last)			Date of birth (m/d/y)
Residence address (street number & name, apartment or suite)	City	State	Zip
Social Security number [ ]	Home phone number	Alternate phone number	

Information about the qualifying group policy(ies)

Name of group policyholder (i.e., your employer or plan administrator)	Policy number(s)

2 Coverage amount information

[[2.1] Disability insurance coverage amount

See section [3] of the Portability Notice for the amount of insurance you are eligible to apply for. You may apply for coverage only if your employer's plan includes this option. You may elect to keep the current amount(s) of disability coverage you had with your prior employer or elect a lower amount. Check one box for each coverage you are requesting to port and write in the amount elected.

[Short-Term Disability ☐ Elect to keep current amount ☐ Elect a lower amount	Amount elected $]
[Long-Term Disability ☐ Elect to keep current amount ☐ Elect a lower amount	Amount elected $]
[Customized Disability insurance ☐ Elect to keep current amount ☐ Elect a lower amount	Amount elected $]

]

[2 Coverage amount information, continued]

[[2.2] Critical Illness insurance coverage amount]

See section [3] of the Portability Notice for the amount of insurance you are eligible to apply for. You may apply for Critical Illness coverage only if your employer's plan includes this option. You may elect to keep the current amount(s) of Critical Illness coverage you had with your prior employer, or elect a lower amount. Check one box for each coverage you are requesting to port and write in the amount elected.

NOTE: Any reference to spouse used below includes your civil union partner.

You may only port spouse/child benefits if you are electing to port your employee benefits and if your spouse/child were insured under the group policy at the time of your termination. Under limited conditions, spouses may be eligible to apply for portable spouse/child insurance. Contact us at the number shown above for details.

[Employee Critical Illness Only insurance ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Employee Critical Illness and Cancer insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Employee Critical Illness, Cancer Only insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]
[Spouse Critical Illness Only insurance ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Spouse Critical Illness and Cancer insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Spouse Critical Illness, Cancer Only insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]
[Child Critical Illness Only insurance ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Child Critical Illness and Cancer insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Child Critical Illness, Cancer Only insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]

If you have elected spouse and/or child(ren) coverage above, be sure to write in the spouse/child(ren) name(s) and date(s) of birth.

Spouse name (first, middle initial, last)	Social Security number [ ]	Date of birth (m/d/y)
Child name (first, middle initial, last)	Social Security number [ ]	Date of birth (m/d/y)
Child name (first, middle initial, last)	Social Security number [ ]	Date of birth (m/d/y)

If you need additional space, check here ☐ and attach a separate sheet.]

3 Premium information

Premium payment

Amount enclosed $	How would you prefer to pay premiums? ☐ Annually ☐ Semi-annually ☐ Quarterly

4 Fraud warnings

[General fraud warning: Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[For AL the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.]

4 Fraud warnings, continued

[For AR, LA, MA, NM, RI, and WV, the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For CO the following warning applies: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.]

[For the District of Columbia the following notice applies: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For FL the following notice applies: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[For KS the following notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.]

[For KY the following notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.]

[For MD the following notice applies: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For ME, TN, VA, and WA the following notice applies: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

[For NJ the following notice applies: Any person who knowingly includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[For OH the following notice applies: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud**.]**

[For OK the following notice applies: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[For OR the following notice applies: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

[For PR the following notice applies: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.]

5 Acknowledgment and signature

To begin processing your request for portability coverage, Sun Life Assurance Company of Canada must receive this signed Application form, any other required documentation, and your first premium within [31] days of your termination date.

No insurance requested in this Application form will become effective until Sun Life Assurance Company of Canada accepts the Application, notifies you of its acceptance, and receives the first premium payment from you. If you submit the initial premium payment with the Application and Sun Life rejects the Application, Sun Life will refund the premium. If your Application is accepted, Sun Life will bill you for future premium payments. Rates will increase when you reach a new age band and may increase for reasons other than age. See the Portability Kit or ask your employer for rates and age bands.

You must read and sign to apply for coverage.
I/We understand and agree that: (1) My/Our eligibility for Portable Group Insurance will be based on the Portability conditions stated in the qualifying group policy(ies). (2) The answers and statements in this Application will be the basis for and become part of any insurance certificate issued as a result of this Application. (3) The certificate issued will replace the coverage provided by the group policy indicated in section 1 of this Application. (4) No insurance requested in this Application will be effective until Sun Life Assurance Company of Canada accepts this Application and receives my initial premium payment. (5) A claim may be denied in accordance with the Incontestability provision of the Portability Certificate if the statements in this Application are not complete and true. (6) All portable insurance will be subject to the terms and conditions of the Portable Group Insurance Certificate and the Group Policy under which it is issued.

Signature of employee X	Date

[(Employee's signature is not required above if spouse is porting due to divorce or death of the employee.)]

[Signature of spouse (if also applying for Critical Illness coverage)] X	Date

Contact us

By mail
Sun Life Assurance Company of Canada
[One Sun Life Executive Park], [SC 3015]
Wellesley Hills, MA 02481

[www.sunlife.com/us]

Customer Service [**800-247-6875]** M–F [8:30 a.m. – 6:00 p.m., ET]

SERFF Tracking #:	*SNLF-128701171*	***State Tracking #:***	***Company Tracking #:*** *2012 CRITICAL ILLNESS-CANCER PORTABILITY*

State:	*Arkansas*	***Filing Company:***	*Sun Life Assurance Company of Canada*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*2012 Critical Illness-Cancer Portability*		
Project Name/Number:	*2012 Critical Illness-Cancer Portability/2012 Critical Illness-Cancer Portability*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved	12/03/2012
Comments:			
Attachment(s):			
Readability Cert .pdf			

		Item Status:	**Status Date:**
Bypassed - Item:	Application	Approved	12/03/2012
Bypass Reason:	Please refer to the Form Schedule Tab.		

		Item Status:	**Status Date:**
Satisfied - Item:	Statements of Variability	Approved	12/03/2012
Comments:			
Attachment(s):			
12-SDPort-C-01 - AR - SOV - Rev 11-14-2012.pdf GMPAP-2548 - SoV - 11-2-12.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Copy of Trust Agreement	Approved	12/03/2012
Comments:			
Attachment(s):			
Sun Life Group Benefits Trust.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Red lined copies	Approved	12/03/2012
Comments:			
Attachment(s):			

SERFF Tracking #:	*SNLF-128701171*	***State Tracking #:***		***Company Tracking #:***	*2012 CRITICAL ILLNESS-CANCER PORTABILITY*

State:	*Arkansas*	***Filing Company:***	*Sun Life Assurance Company of Canada*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*2012 Critical Illness-Cancer Portability*		
Project Name/Number:	*2012 Critical Illness-Cancer Portability/2012 Critical Illness-Cancer Portability*		

12-SDPort-C-01 - AR - Critical Illness Portability 11-14-12 - Red Lined for Dept.pdf
GMPAP-2548 - Rev 11-2-12 - Red-Lined.pdf

CERTIFICATE OF COMPLIANCE

This is to certify that the text of the submitted forms has achieved a Flesch reading ease score that meets your department's requirements.

Form Number	Score
12-SDPort-C-01	50.5
GMPAP-2548	50.1

SUN LIFE ASSURANCE COMPANY OF CANADA

Thomas Miele
Assistant Vice President

Sun Life Assurance Company of Canada
Statement of Variability

Form #: 12-SDPort-C-01

Revision Date: November 14, 2012

Variability denoted by bracketing

Field	Scope of Variation
Cover Page	
Executive Office	Executive Office address, telephone and internet address reflects current information but may be changed to reflect new address, telephone or internet address.
Policy Number	Hypothetical - John Doe specimen information.
Policy Effective Date	Hypothetical - John Doe specimen information.
Policyholder	Hypothetical - John Doe specimen information.
Certificate Number	Hypothetical - John Doe specimen information.
Certificate Effective Date	Hypothetical - John Doe specimen information.
Issue State	Hypothetical - John Doe specimen information.
Company Officers	In the event the signature or title of an officer signing the form changes, any new signature or title utilized will be that of an officer of the company.
Critical Illness and Cancer	Text will change to reflect the actual coverage election by the Policyholder and/or Employee and may include Critical Illness, Critical Illness and Cancer, or Cancer Only.
Corporate logo	Will vary to reflect future change.
Notice to Certificateholder language	Added this language as required by Arkansas Statute: 23-79-138. Variability within this page is to accommodate future changes.
TABLE OF CONTENTS	
TABLE OF CONTENTS	Text and Section numbers will change to reflect the actual coverage election by the Policyholder and/or Employee and may include: • Spouse Insurance • Dependent Children Insurance
1. BENEFIT HIGHLIGHTS	
Participant	Hypothetical - John Doe specimen information.
Premium Due Date	Text will appear to the extent premiums are required for coverage. Frequency will vary and may include: • The first day of each month • The first day of each quarter • The first day of each year

Field	Scope of Variation
Participant Insurance Amount	The amount of insurance and Minimum may vary between $5,000 - $100,000. If a range of insurance amounts are available, then Change Increment Amount and Minimum will print. Change Increment Amount varies between $1,000 - $25,000. The Insured is John Doe specimen information.
Spouse Insurance Amount	The amount of insurance and Minimum may vary between $5,000 - $100,000. If a range of insurance amounts are available, then Change Increment Amount and Minimum will print. Change Increment Amount varies between $1,000 - $25,000. The Insured is John Doe specimen information.
Dependent Children Insurance	The amount of insurance and Minimum may vary between $5,000 - $100,000. If a range of insurance amounts are available, then Change Increment Amount and Minimum will print. Change Increment Amount varies between $1,000 - $25,000. The Insured is John Doe specimen information.
Circulatory Conditions Category	Text will show with Participant election of the type of insurance and the Covered Conditions that may apply from the list shown below for the plan issued. The Benefit Percentage ranges from 10% to 100% for each benefit. • Heart Attack • Stroke • Heart Transplant • Coronary Artery Bypass Surgery • Aortic Surgery • Coronary Artery Angioplasty The following Covered Condition will apply in place of Heart Transplant when the plan is issued in connection with an HDHP/HSA program: • End-stage Heart Failure
Cancer Conditions Category	Text will show with Participant election of the type of insurance and the Covered Conditions that may apply from the list shown below for the plan issued. The Benefit Percentage ranges from 10% to 100% for each benefit. • Cancer • Non-Life Threatening Cancer
Other Conditions Category	Text will show with Participant election of the type of insurance and the Covered Conditions that may apply from the list shown below for the plan issued. The Benefit Percentage ranges from 10% to 100% for each benefit. • Benign Brain Tumor • Coma • Major Organ Failure • Paralysis • Severe Burns
Covered Childhood Conditions Category	Text will show with Participant election of Dependent Children Insurance and the Covered Conditions that may apply from the list shown below for the plan issued. The Benefit Percentage ranges from 10% to 100% for each benefit. • Cystic Fibrosis • Congenital Heart Disease • Cerebral Palsy • Type 1 Diabetes Mellitus • Muscular Dystrophy The following Covered Conditions will apply in place of Congenital Heart Disease when the plan is issued in connection with an HDHP/HSA program: • Complex Congenital Heart Disease
Maximum Benefits Payable for each Insured under this Certificate	The percentage of the benefit for Covered Conditions in the same category may change between 100% - 200%. If there is a benefit cap beyond Covered Conditions in the same category, the percentage may change between 100% - 400%. Changes will be based on a future determination by the Company after an actuarial pricing evaluation. Any pricing change would apply to new issues on a going forward basis only.
2. DEFINITIONS	

Field	Scope of Variation
Clinical Diagnosis	Text will show if Cancer coverage is elected.
Critical Illness	The bracketed text will not show when the plan is issued in connection with an HDHP/HSA program.
Dependent Child	Text will show if Dependent Children Insurance is elected and will change based on requirements specified by the Policyholder, the requirements of the Affordable Care Act, benefits mandated by state laws or regulations, or additional federal legislation. The child may or may not be required to be unmarried. The child's age may vary between 23 – 30, may be required to be a student and be reliant on the Participant for 25% - 75% of the child's support. An exception may exist for a child enrolled in an employer-sponsored medical plan other than the parent's. A Dependent Child can include: • an Participant's unmarried step-child; • a child for whom the Participant has legal guardianship; • a foster child placed with the Participant by a licensed agency; • an Participant's adopted child, including any child placed with the Participant for adoption; • an E Participant's grandchild who may or may not depend on the Participant for support; • a child for whom coverage is required pursuant to a Qualified Medical Child Support Order or other court administrative order; or • a child of a Spouse. If Policyholder plan requirements include children older than a specified age, the plan may require the child be such as the following: • incapable of self-sustaining employment because of a mental retardation, developmental disability or physical handicap; and • dependent on the Participant for between 25% - 75% % or more of his/her support. Dependent Child coverage may be limited to one parent if both parents are eligible for the same Participant coverage. Exceptions may also exist similar to the following: • any person who is insured as a Participant; or • any person residing outside the United States. This exclusion may or may not apply to a Dependent Child who resides with a Participant who is on a temporary work assignment outside the United States. The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable.
Divorce	Text will show if Spouse Insurance is elected.
Marriage	Text will show if Spouse Insurance is elected. The definition of Marriage will change to the extent necessary to meet Policyholder plan designs and comply with state laws and regulations regarding legally recognized same-sex unions and domestic partnerships.
Spouse	Text will show if Spouse Insurance or Portability is elected under the Policyholder's plan. The definition of Spouse will change to the extent necessary to meet Policyholder plan designs and comply with state laws and regulations regarding legally recognized same-sex unions and domestic partnerships. Exceptions may also exist similar to the following: • any person who is insured as an Employee; or • any person residing outside the United States. This exclusion does not apply to a Spouse who resides with an Employee who is on a temporary work assignment outside the United States. The Policyholder's plan may exclude any person residing outside of the U.S., Mexico, or Canada. Another country could be included if applicable.

Field	Scope of Variation
3. PORTABILITY	
When are you eligible for portability insurance?	60 months may vary between 12 months - 120 months. The Policyholder plan may require the Insured to be under qualifying group policy coverage for a certain amount of time for it to be portable. 36 consecutive months may vary between 12 consecutive months - 48 consecutive months. Any or all of the following may appear: • leave of absence • labor strike • retirement • sickness • injury The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable. The Policyholder's plan may exclude portability if other coverage with the company was already ported. The Policyholder's plan may exclude portability if the insured is over a specified age. Age 70 may vary between 35 - 99.
What is the amount of portable insurance?	100% may vary between 25% - 100%.
When is portability available to the Spouse and when is the Spouse eligible?	Text will appear to reflect the actual coverage election by the Policyholder and/or Participant. 60 months may vary between 12 months - 120 months. Any or all of the following may appear: • die • Divorce your Spouse • are terminated The Policyholder plan may require the Insured to be under qualifying group policy coverage for a certain amount of time for it to be portable. 36 consecutive months may vary between 12 consecutive months - 48 consecutive months. The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable. Age 70 may vary between 35 - 99. Any or all of the following may appear: • death • Divorce • termination

Field	Scope of Variation
What is the amount of the Spouse's portable insurance?	100% may vary between 25% - 100%. Any or all of the following may appear: • death • Divorce • termination Text regarding Dependent Children Insurance based on Policyholder election of same.
When does the Spouse's portable insurance start?	Any or all of the following may appear: • death • Divorce • termination
4. EFFECTIVE DATES AND TERMINATION OF PARTICIPANT INSURANCE	
How can you make changes in Participant Insurance?	Decreases may be subject to the limits shown in Benefit Highlights section (e.g. one level decrease or a specific dollar amount decrease).
When does Participant Insurance end?	60 months may vary between 12 months - 120 months. If the duration will be to Age 70 or is unlimited, this sentence will be removed. Participant age may or may not be a determining factor of when Participant Insurance Ends. Age 70 may vary between 35 - 99. If the duration will be unlimited, this sentence will be removed. The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable. Participant Insurance may terminate if the Participant is again under the qualifying group insurance policy.
5. EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE	
5. EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE	Text will appear if elected by the Policyholder and/or Participant.
How can you make changes in Spouse Insurance?	Decreases may be subject to the limits shown in Benefit Highlights section (e.g. one level decrease or a specific dollar amount decrease).
When does Spouse Insurance end?	60 months may vary between 12 months - 120 months. If the duration will be to Age 70 or is unlimited, this sentence will be removed. Spouse age may or may not be a determining factor of when Spouse Insurance Ends. Age 70 may vary between 35 - 99. If the duration will be unlimited, this sentence will be removed. The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable. Spouse Insurance may terminate if the Participant is again under the qualifying group insurance policy.
6. EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE	
6. EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE	Text will appear and Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.

Field	Scope of Variation
How can you make changes in Dependent Children Insurance?	Decreases may be subject to the limits shown in Benefit Highlights section (e.g. one level decrease or a specific dollar amount decrease).
When does Dependent Children Insurance end?	60 months may vary between 12 months - 120 months. If the duration will be to Age 70 or is unlimited, this sentence will be removed. The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable. Dependent Children Insurance may terminate if the Participant is again under the qualifying group insurance policy.
7. PREMIUMS	
7.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
When are your premiums due and how are they determined?	The Executive Office may be changed to our Service Office or a specific address we designate for the collection of premiums. If Canadian dollars are accepted as premium, the following language may appear: • and Canadian dollars; • and Canadian dollars at the accepted daily rate of exchange.
Can premium rates that apply to your insurance change?	We may reserve the right to recalculate the premium rate after an initial time period. 12 months may vary between 12 months - 60 months.
What is the grace period?	31-day may vary between 31-day - 365-day.
8. BENEFIT PROVISIONS	
8.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
What benefits are payable?	The bracketed text will not show when the plan is issued in connection with an HDHP/HSA program.
9. COVERED CONDITIONS	
9.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
What Critical Illness conditions are covered?	The bracketed text will not show when the plan is issued in connection with an HDHP/HSA program.

Field	Scope of Variation
Circulatory Conditions Category	Text will show with Policyholder and/or Participant election of the type of insurance and the Covered Conditions that apply from the list shown below for the plan issued. • Heart Attack • Stroke • Heart Transplant • Coronary Artery Bypass Surgery • Aortic Surgery • Coronary Artery Angioplasty 30 days could vary between 15 - 180 days. The following will show in place of Heart Transplant when the plan is issued in connection with an HDHP/HSA program: **[End-stage Heart Failure** means a confirmed diagnosis of severe and irreversible failure of the heart which is not remediable by medical or device therapy or by surgical therapy other than heart transplant. To qualify under End-stage Heart Failure, the Insured must be listed with the United Network of Organ Sharing (UNOS) on a Heart Transplant waiting list. Severe and irreversible failure of the heart shall be conclusively proven if an Insured has undergone a Heart Transplant as the recipient while insured under the Policy. The diagnosis of End-stage Heart Failure must be made by a Specialist Physician.]
Cancer Conditions Category	Text will show with Policyholder and/or Participant election of the type of insurance and the Covered Conditions that apply from the list shown below for the plan issued. • Cancer • Non Life-Threatening Cancer • Cancer Benefit Waiting Period • Non-Life Threatening Cancer Benefit Waiting Period Text regarding recurrence will show based on a future product design change. 30 days could vary between 15 - 180 days. 6 months could vary between 30 days - 36 months.
Other Conditions Category	Text will show with Policyholder and/or Participant election of the type of insurance and the Covered Conditions that apply from the list shown below for the plan issued. • Benign Brain Tumor • Coma • Benign Brain Tumor Benefit Waiting Period • Major Organ Failure • Paralysis • Severe Burns Text regarding recurrence will show based on a future product design change. 30 days and 90 days could vary between 15 - 180 days. 6 months could vary between 30 days - 36 months.
Major Organ Failure	The first bulleted item in brackets under the first paragraph is replaced with the following when the plan is issued in connection with an HDHP/HSA program: • for kidney failure only, in the absence of a listing on UNOS, ongoing dialysis (either hemo or peritoneal) on a permanent basis, shall be conclusive proof of irreversible end-stage kidney failure; The first bulleted item in brackets under the third paragraph is replaced with the following when the plan is issued in connection with an HDHP/HSA program: • for kidney failure only, in the absence of a listing on UNOS, ongoing dialysis (either hemo or peritoneal) on a permanent basis, shall be conclusive proof of irreversible end-stage kidney failure,

Field	Scope of Variation
Childhood Conditions Category	Text will show with Policyholder and/or Participant election of Dependent Children Insurance and a Covered Condition as shown below. • Cystic Fibrosis • Congenital Heart Disease • Cerebral Palsy • Type 1 Diabetes Mellitus • Muscular Dystrophy • Childhood Conditions Benefit Waiting Period 30 days could vary between 15 - 180 days. 6 months could vary between 30 days - 36 months.
Congenital Heart Disease	The following will show in place of Congenital Heart Disease when the plan is issued in connection with an HDHP/HSA program: **Complex Congenital Heart Disease** means a confirmed Diagnosis of at least one of the following covered heart conditions: • coarctation of the aorta; • Ebstein's anomaly; • Eisenmenger syndrome; • Tetralogy of Fallot; • transposition of the great vessels; or • any other congenital cardiac condition that requires life-saving, open heart surgery to survive. It also means any one of the following specific conditions that require life-saving, open heart surgery to survive: • aortic stenosis; • atrial septal defect; • discrete subvalvular aortic stenosis; • pulmonary stenosis; or • ventricular septal defect. The Diagnosis of Complex Congenital Heart Disease must be made and the surgery must be recommended by a Specialist Physician and supported by cardiac imaging acceptable to us.
10. LIMITATIONS AND EXCLUSIONS	
10.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
What exclusions apply to the benefits payable?	The second bulleted item bracketed under the first paragraph will not show when the plan is issued in connection with an HDHP/HSA program. Any combination of the following exclusions may show if applicable under the Policyholder's plan: • active participation in a riot, rebellion or insurrection; • committing or attempting to commit an assault, felony or other criminal act; • your engagement in scuba diving, parachuting, hang gliding, motorized racing, ballooning, kick-boxing, cliff diving, mountain climbing, powerboat racing, heli-skiing, big game hunting, cave exploration, extreme sports, underwater diving, rodeo events or white water rafting, where there is a likelihood of death or serious injury; • being legally intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed; or • improper or illegal use of inhalants or huffing
What limitations apply to the benefits payable?	12 months will vary between 12 and 24 months.

Field	Scope of Variation
Pre-Existing Condition	The look-back from the effective date of coverage will vary between 3, 6, or 12 months. Text will be included regarding increases in insurance if same is allowed under the Policyholder's plan. Text regarding symptoms for which an ordinarily prudent person would have consulted a health care provider may show if required under the Policyholder plan.
What are the maximum benefits payable under this Certificate?	Text regarding one benefit payment will not show if a recurrence benefit rider is elected. The percentage of the benefits payable for all Covered Conditions in the same category may change between 100% - 200%. The percentage of the benefits payable for all the Covered Conditions in all Categories may change between 100% - 400%.
11. CLAIMS	
11.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
When does written Notice of Claim have to be submitted?	60 and 90 days may vary from 30 days - 24 months based on Policyholder requirements and as mandated by state laws or regulations.
When does written Proof of claim have to be submitted?	120 days may vary from 90 days - 24 months based on Policyholder requirements and as mandated by state laws or regulations.
When will a decision on your claim be made?	45 days and 30 day may vary from 10 days – 45 days based on ERISA requirements and as mandated by Federal laws or regulations.
What if your claim is denied?	Text will show if the plan is subject to ERISA and may vary to comply with federal requirements.
Can you request a review of a claim denial?	180 days may vary from 90 days - 365 days. 45 days may vary from 10 days – 45 days based on Policyholder requirements and as mandated by state laws or regulations.
What if your claim is denied on review?	Text will show if the plan is subject to ERISA.
To whom are benefits payable?	$5,000 may vary between $1,000 - $10,000 based on ERISA requirements and as mandated by Federal laws or regulations.
12. GENERAL PROVISIONS	
12.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
ASSIGNMENT	Text will show if the benefits are assignable.
LEGAL PROCEEDINGS	60 days may vary between 60 days - 90 days. 3 years may vary between 2 years – 3 years.
LIMIT OF PREMIUM REFUNDS	12 months may vary between 6 months - 36 months.
BACK PAGE	

Field	Scope of Variation
Critical Illness and Cancer	Text will change to reflect the actual coverage election by the Policyholder and/or Employee and may include Critical Illness, Critical Illness and Cancer, or Cancer Only.
Corporate logo	Will vary to reflect future change.

Sun Life Assurance Company of Canada
Statement of Variability

Form #: GMPAP-2548

Revision Date: November 2, 2012

Variability denoted by bracketing

Field	Scope of Variation
Header	Text will show to the extent Disability and/or Critical Illness coverage is available for Portability. Section numbers will change to reflect the actual coverage options available for Portability.
1. General information	
Social Security No.	Variability only to the extent that the company may ask for the last four digits of the Social Security number or the whole Social Security number. Information is to be used to identify those to whom benefits are payable.
2. Coverage amount information	
Disability insurance coverage amount	Text will show to the extent Disability coverage is available for Portability. Section numbers will change to reflect the actual coverage options available for Portability. Section numbers of the Portability Notice could change to reflect changes in administrative requirements Options under this category will appear to the extent they are is available for Portability and include: • Short Term Disability • Long Term Disability • Customized Disability
Critical Illness insurance coverage amount	Text will show to the extent Critical Illness coverage is available for Portability. Section numbers will change to reflect the actual coverage options available for Portability. Section numbers of the Portability Notice could change to reflect changes in administrative requirements Options under this category will appear to the extent they are is available for Portability and include: • Employee Critical Illness Only insurance • Employee Critical Illness and Cancer insurance • Employee Critical Illness, Cancer Only insurance • Spouse Critical Illness Only insurance • Spouse Critical Illness and Cancer insurance • Spouse Critical Illness, Cancer Only insurance • Child Critical Illness Only insurance • Child Critical Illness and Cancer insurance • Child Critical Illness, Cancer Only insurance Social Security number variability only to the extent that the company may ask for the last four digits of the Social Security number or the whole Social Security number. Information is to be used to identify those to whom benefits are payable.

Field	Scope of Variation
4. Fraud Warning	
Fraud warnings	The fraud warning sections are bracketed only so that we may change fraud language to comply with future changes to state law or regulation.
5. Acknowledgment and signature	
	31 days may vary between 30 days - 180 days. Signature of Employee may not be required in the case of a porting Spouse. Spouse signature may be required if applying for Critical Illness coverage.
Contact us	
Contact Information	Office address, telephone and internet address reflects current information but may be changed to reflect new address, telephone or internet address.

The Sun Life Group Benefits Trust

THIS TRUST AGREEMENT, entered into as of this **1st** day of **January, 2001**, by and between **Sun Life Assurance Company of Canada** a corporation organized under the laws of Canada (which with any successor or successors thereto is hereinafter referred to as the "Settlor") and **Bank of Newport,** a Rhode Island financial institution organized under the laws of the State of Rhode Island and established in the city of Newport (which, with any successor or successors thereto is hereinafter referred to as the "Trustee"), is made for the purpose of having group insurance contracts (hereinafter, together with any riders, endorsements or amendments thereto, referred to as the "Contracts") issued to the Trustee in accordance with the applicable provisions of the laws regulating the business of insurance for the benefit of individuals insured under group policies issued by Sun Life Assurance Company of Canada. The trust is entitled **The Sun Life Group Benefits Trust** (hereinafter referred to as the "Trust").

In consideration of the mutual covenants and agreements herein, it is hereby agreed as follows:

1. **THE TRUST FUND** - The Trust Fund shall consist of the insurance Contracts issued to the Trustee and any cash received by the Trustee for purposes of the Trust. The Trustee will apply for such Contracts as are from time to time designated by the Settlor in writing, to the extent such applications are required. The sole responsibility of the Trustee under the Contracts and under the terms of this Trust Agreement will be to hold the Contracts as Contractholder. As Contractholder, the Trustee will execute the Contracts if requested by the Settlor to do so, and will upon the written direction of the Settlor accept for addition to the Contracts and will execute in accordance with such direction any riders, endorsements or amendments to the Contracts as may be supplied to the Trustee by the Settlor.

THE INSURANCE FUND - The Insurance Fund shall consist of the premiums paid by the participants or insureds to the Insurer to purchase insurance under the Contracts. The Insurance Fund shall be part of the Trust Fund, but shall not be the responsibility of the Trustee to administer.

2. **SOLE DUTY AND RESPONSIBILITY OF TRUSTEE** - The Trustee will have no duties or responsibilities other than to be Contractholder of the Contracts as set forth in Section 1 of this Trust Agreement and shall have no responsibility whatsoever to exercise any rights or options under the Contracts except as directed in writing by the Settlor. As Contractholder, the Trustee assumes no discretionary responsibilities and does not act as a fiduciary except with respect to exercising its duties as Contractholder. Without limiting the foregoing, it is specifically agreed that:

(a) No payments under the Contracts will be the responsibility of the Trustee or payable to the Trustee. Payments under the Contracts will be made to the insureds, beneficiaries or other persons entitled thereto under the Contracts.

(b) No person will have any financial interest in or claim against the Trust or the Trustee with respect to benefits payable under the Contracts or otherwise.

(c) Neither the Trust nor the Trustee will be liable to any person for any action or failure to take action by the Settlor.

(d) The Trustee will not engage in marketing, solicitation, collection of premiums or dividends, benefit payment, record keeping or other administrative function.

(e) The Trustee will have no investment powers or responsibilities or duty to preserve the assets of the Trust and will have no duty or responsibility to monitor or review the investment decisions or responsibilities, if any, of any person or organization with respect to this Trust.

(f) The Trustee will not be liable for the form, genuineness, validity, sufficiency or effects of the Contracts, nor for any act of any person or persons that may render the Contracts null and void. The Trustee shall have no authority to determine what Contracts are held in the Trust or the terms of such Contracts or control over management or disposition of such Contracts.

(g) The Trustee will not be liable for any delay in any payment under the Contracts resulting from any provision herein or otherwise nor should the Contracts lapse or otherwise will the Trustee be liable.

(h) The Trustee will have no responsibility in connection with the execution or approval of any document (including any application) with respect to participation in the Contracts.

(i) The Trustee shall not be required to undertake or defend any litigation which may arise by reason of the existence of the Contracts or this Agreement unless first satisfactorily indemnified in accordance with Section 6 of this Agreement.

Nothing in this Section 2, however, will operate to reduce or avoid any liability of the Trust or Trustee for breach of the Trustee's duty to apply for and hold the Contracts, and to accept and execute certain documents, in accordance with Section 1 of this Trust Agreement.

3. **TERMINATION OF TRUST; REPLACEMENT OF TRUSTEE** - This Trust may be terminated by written notice from the Settlor to the Trustee. It may not be terminated by the Trustee without the written approval of the Settlor.

The Trustee may resign its trusteeship at any time, upon not less than 30 days written notice to the Settlor, or upon the appointment of a successor trustee, whichever is sooner. The Settlor may remove the Trustee at any time upon not less than 30 days written notice to the Trustee. Upon such resignation or removal, the Settlor will appoint a successor trustee which will accept the trusteeship in writing. Should the trust be terminated or should the Trustee resign or be removed and no successor trustee has been appointed within 30 days of the resignation or removal, the Trustee will immediately return the Contracts to the Settlor and will no longer be the Contractholder thereunder. Upon transfer and delivery of the Contracts to the successor trustee or the Settlor, the Trustee shall be fully released and discharged from all further obligations and liabilities hereunder, any successor trustee shall succeed to and be vested with all of the powers, rights, discretions, obligations and immunities conferred upon the Trustee.

No Trustee hereunder shall be obligated to review the acts, or failure to act, of any prior Trustee, nor shall any Trustee be liable for the acts, or failure to act, of any prior Trustee.

4. **RELIANCE BY TRUSTEE** - The Trustee may rely upon any certificate, notice or direction purporting to have been signed by or on behalf of the Settlor which the Trustee reasonably believes to be genuine. The Trustee shall not be bound by any notice or direction from the Settlor unless or until it shall have been received in writing at its office in Newport, Rhode Island. Notices or communications from the Trustee to the Settlor shall be sent to the address identified by the Settlor to the Trustee as the appropriate one for communications regarding the Trust.

5. **TRUSTEE'S FEE AND EXPENSES** - The Trustee may charge a reasonable fee for its services and shall be reimbursed for any expenses incurred by it. The Trustee may employ legal counsel of its own choosing and shall be reimbursed for the fees incurred. All such fees and expenses, including legal fees, shall be paid by the Settlor.

6. **INDEMNIFICATION OF TRUSTEE** - The Trust and Trustee shall be indemnified, protected and held harmless by the Settlor against any and all costs, expenses, attorneys' fees, losses, judgments and liabilities of any nature arising out of any claim, demand or cause of action, whether asserted by the Trust or Trustee against another or by another against the Trust, the Trustee or anyone else, resulting from or in any manner related to the Trust or to the Trustee serving as or having served as Trustee of the Trust. In addition, the Trustee shall be indemnified by Sun Life Assurance Company of Canada for all costs, expenses and liabilities, including attorneys' fees, incurred by the Trustee in the performance of its duties hereunder.

7. **ENTIRE AGREEMENT** - This Trust Agreement represents the entire agreement between the Settlor and the Trustee. It may be amended or modified only by written agreement between the Settlor and Trustee.

8. **APPLICABLE LAW** - This Trust Agreement is delivered to and accepted by the Trustee in the State of Rhode Island and is in all respects to be governed by the laws of Rhode Island.

This Trust Agreement is duly executed by:

SUN LIFE ASSURANCE COMPANY OF CANADA
(Settlor)

BY: Stephen Bailey

TITLE: VP Group Products

BY: M E Hennessy

TITLE: VP Grp Insurance

BANK OF NEWPORT
(Trustee)

BY: Ann M. Nagle

TITLE: Vice President

SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
[One Sun Life Executive Park]
[Wellesley Hills, MA 02481]

[(800) 247-6875]
[www.sunlife.com/us]

Sun Life Assurance Company of Canada certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

Policy Number:	[00000001]
Policy Effective Date:	[September 1, 2012]
Policyholder:	[ABC Trust]
Certificate Number:	[12345]
Certificate Effective Date:	[September 1, 2012]
Issue State:	[Massachusetts]

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

This Certificate contains the terms of the Group Insurance Policy that affect your insurance. This Certificate is part of the Group Insurance Policy.

This Certificate is governed by the laws of the Issue State shown above.

Signed at Wellesley Hills, Massachusetts.

[Dean A. Connor]
[President and Chief Executive Officer]

[Dana J. Easthope]
[Vice-President, Associate General Counsel and Corporate Secretary]

Group Critical Illness Insurance Certificate
[Critical Illness and Cancer]

Non-Participating

[Sun Life Financial℠]

NOTICE TO CERTIFICATEHOLDER

THIS NOTICE IS TO ADVISE YOU THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING YOUR SUNLIFE GROUP INSURANCE PLAN, YOU MAY CONTACT THE FOLLOWING:

SUN LIFE ASSURANCE COMPANY OF CANADA
[GROUP CUSTOMER SERVICE CENTER SC1219
U.S. HEADQUARTERS OFFICE
ONE SUN LIFE EXECUTIVE PARK
WELLESLEY HILLS, MA 02481
(800) 247-6875

ALSO AVAILABLE TO YOU IS THE CONSUMER SERVICES DIVISION OF THE ARKANSAS INSURANCE DEPARTMENT, [1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS 72201-1904, (501) 371-2640 or (800) 852-5494]

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1. BENEFIT HIGHLIGHTS

Participant: **John Doe**

[Premium Due Date: [The first day of each month] **]**

Insurance Amounts

[Participant Insurance Amount: [$100,000]
[Change Increment Amount: [$5,000]]
Minimum: [$5,000]
Insured: [John Doe] **]**

[Spouse Insurance Amount: [$100,000]
[Change Increment Amount: [$5,000]]
Minimum: [$5,000]
Insured: [Jane Doe] **]**

[Dependent Children Insurance:
[Change Increment Amount: [$5,000]]
Minimum: [$5,000]
Insured: [Bill Doe] [$100,000]
[Insured: [Bob Doe]] [$100,000] **]**

[Circulatory Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Heart Attack	[100%]]
[Stroke	[100%]]
[Heart Transplant	[100%]]
[Coronary Artery Bypass Surgery	[25%]]
[Aortic Surgery	[25%]]
[Coronary Artery Angioplasty	[25%]] **]**

[Cancer Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Cancer	[100%]]
[Non-Life Threatening Cancer	[25%]] **]**

[Other Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Benign Brain Tumor	[100%]]
[Coma	[100%]]
[Major Organ Failure	[100%]]
[Paralysis	[100%]]
[Severe Burns	[100%]] **]**

[Childhood Conditions Category - [Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Cerebral Palsy	[100%]]
[Congenital Heart Disease	[100%]]
[Cystic Fibrosis	[100%]]
[Type 1 Diabetes Mellitus	[100%]]
[Muscular Dystrophy	[100%]] **]**

Maximum Benefits Payable for each Insured under this Certificate:

- We will only pay one benefit for each Covered Condition shown above;
- We will not pay more than an aggregate of [100%] of the benefit payable for Covered Conditions in the same Category**[**; and
- We will not pay more than an aggregate of [200%] of the benefit payable for all the Covered Conditions in all Categories shown above].

Note: All benefits available for Covered Conditions under this portability Certificate will be reduced by any benefits paid or payable under the Qualifying Group Insurance Policy. The Maximum Benefits available under this Certificate shall be reduced by any benefits paid or payable under the Qualifying Group Insurance Certificate.

2. DEFINITIONS

Benefit Percentage means the percentage that is applied to your Insurance Amount to determine the amount of Critical Illness benefits payable under the Policy.

[**Clinical Diagnosis** means a Diagnosis of Cancer based on observation and history, diagnostic and laboratory studies, and symptoms.]

Critical Illness means only the illnesses [or procedures] defined in the Covered Conditions section of this Certificate for which benefits are payable.

[Dependent Child means the Participant's:
- [[unmarried] child from live birth to under age [26] [who is enrolled as a full time student and depends on the Participant for [50%] or more of the child's support.]]

Dependent Child includes:
- **[**a Participant's [unmarried] step-child];
- [a child for whom the Participant has legal guardianship];
- [a foster child placed with the Participant by a licensed agency];
- a Participant's adopted child, including any child placed with the Participant for adoption;

[If [an] [unmarried] child is age [26] or older and is:
- **[**incapable of self-sustaining employment because of a mental retardation, developmental disability or physical handicap]; [and
- dependent on the Participant for **[[**50%] or more of his/her**]** support;**]**

that child will continue to be a Dependent under the Policy for as long as these conditions exist.**]**

[No person may be considered to be a Dependent Child of more than one Participant.]

Dependent Child does not include:
- **[**any person who is insured as a Participant; or]
- any person residing outside the [United States], [Canada], or [Mexico]. [This exclusion does not apply to a Dependent Child who resides with a Participant who is on a temporary work assignment outside the [United States].**]**

Diagnosis (Diagnosed) means a definitive identification of the Critical Illness made during the lifetime of the Insured by a Specialist Physician:
- supported by documentation of all appropriate and defined studies;
- based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
- meeting any diagnostic requirements stated in this Certificate for the particular Critical Illness being diagnosed.

[**Divorce** means the dissolution of any relationship identified in the Marriage definition and the term "divorce decree" means the court-issued document appropriate for the termination of such a relationship.]

Insurance Amount means the amount of insurance available under the Policy as shown in the Benefit Highlights and for which a person covered under the Policy is insured.

Insured means any person covered under the Policy as named in the Benefit Highlights.

[Marriage means any of the following relationships recognized under applicable state law: a same-sex or opposite-sex marriage; a civil union partnership under which the partners have the same legal rights and

responsibilities as a married couple; [and a same-sex or opposite-sex registered domestic partnership under which the partners have the same legal rights and responsibilities as a married couple.]**]**

Participant means a person who was insured under a Qualifying Group Insurance Policy and who applied for insurance under the Policy. The Participant eligible for insurance under this Certificate is shown in the Benefit Highlights.

Physician means an individual who is operating within the scope of his or her license and is either:

- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

The Physician cannot be you, a business associate or any family member. “Family member” means: (a) your spouse and (b) the following relatives of you or your spouse: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Policy means the group insurance policy under which this Certificate is issued.

Proof means any medical, financial, or other information that is required under by us and is satisfactory to us.

Qualifying Group Insurance Policy means the group insurance policy we issued which included the portability option to apply for insurance under the Policy.

Specialist Physician means a medical doctor who is licensed and practicing in the United States or Canada and who has completed an accredited specialty training program recognized by the American Board of Medical Specialties and has passed the examination leading to Board Certification in the field most applicable to the condition being evaluated or equivalent certification acceptable to us.

[Spouse means any individual who under applicable state law is either recognized as a spouse, partner to a civil union[, a partner to a registered domestic partnership] under which the partners have the same legal rights and responsibilities as a married couple, or are otherwise accorded the same rights as a spouse.

Spouse does not include any person residing outside the [United States], [Canada], or [Mexico]. [This exclusion does not apply to a Spouse who resides with a Participant who is on a temporary work assignment outside the [United States].] **]**

Treatment means a Physician's consultation, care or services; diagnostic measures; or the prescription, refill or taking of prescribed drugs or medicines.

We, Us, Our (we, us, our) means Sun Life Assurance Company of Canada.

You, Your (you, your) means the Participant who is eligible for insurance under this Certificate.

3. PORTABILITY

When are you eligible for portability insurance?
You are eligible under the Qualifying Group Insurance Policy to elect to continue your insurance for up to [60 months] if all of the following requirements are met:

- [you have been validly Insured under the Qualifying Group Insurance Policy for at least [36 consecutive months];]
- your insurance ends because you terminate employment for reasons other than [leave of absence, labor strike, retirement, sickness or injury];
- the Qualifying Group Insurance Policy is still in force;
- you reside in the United States [or Canada];
- [you have not exercised your portability right under a similar certificate issued by us;] and
- you are under age [70] at the time employment terminates.

Your new portability insurance is provided by this Certificate. Your new portability insurance may not be identical to your current insurance under the Qualifying Group Insurance Policy.

What is the amount of portable insurance?
You may apply for portable insurance in an amount up to [100%] of each Insured's remaining amount of insurance validly in force under the Qualifying Group Insurance Policy on the date your insurance terminates. In no instance will the insurance issued under this Certificate be greater than the remaining amount of insurance in force under the Qualifying Group Insurance Policy on the date such insurance terminates. Your new portability insurance policy will not provide any benefits beyond those described in this Certificate.

When does your portable insurance start?
After your insurance under the Qualifying Group Insurance Policy terminates, your portable insurance provided by this Certificate starts on the later of the following:

- the date we approve your application for portable insurance; and
- the date we receive your first premium payment for portable insurance.

[When is portability available to the Spouse and when is the Spouse eligible?
Portability is available for the Spouse under the Qualifying Group Insurance Policy for up to [60 months] if all of the following requirements are met:

- the employee under the Qualifying Group Insurance Policy [dies] [or Divorces their Spouse];
- **[**the employee under the Qualifying Group Insurance Policy had been Insured under the Policy for at least [36 consecutive months];**]**
- the Qualifying Group Insurance Policy is still in force;
- the Spouse resides in the United States [or Canada]; and
- the Spouse is under age [70] at the time of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy.

The Spouse's new portability insurance is provided by this Certificate. Their new portability insurance may not be identical to the insurance under the Qualifying Group Insurance Policy.

What is the amount of the Spouse's portable insurance?
The Spouse may apply for portable insurance in an amount up to [100%] of the remaining amount of [Spouse Insurance] [and Dependent Children Insurance] in force under the Qualifying Group Insurance Policy on the date of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy. In no instance will the [Spouse Insurance] [and Dependent Children Insurance] issued under this Certificate be greater than the remaining amount of [Spouse Insurance] [and Dependent Children Insurance] in force under the Qualifying Group Insurance Policy on the date of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy. The Spouse's new portability insurance policy will not provide any benefits beyond those described in this Certificate.

[The Spouse may not apply for portable insurance for a Dependent Child whose insurance has not terminated under the Qualifying Group Insurance Policy due to Divorce.]

When does the Spouse's portable insurance start?
After the [Death] [or Divorce] of the employee under the Qualifying Group Insurance Policy, the Spouse's portable insurance will start on the later of the following:

- the date we approve the Spouse's application for portable insurance; and
- the date we receive the Spouse's first premium payment for portable insurance.**]**

4. EFFECTIVE DATES AND TERMINATION OF PARTICIPANT INSURANCE

When does Participant Insurance start?
Participant Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

How can you make changes in Participant Insurance?
You may request a decrease in your Participant Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease your Participant Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Participant Insurance start?
Any reduction in your Participant Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Participant Insurance end?
Your Participant Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- [the date you attain age [70];]
- the last day for which any required premium has been paid for your Participant Insurance;
- the date you request in writing to end your Participant Insurance;
- [the date you reside outside the United States [or Canada;]
- [the date you become insured again under the Qualifying Group Insurance Policy;] or
- the date all benefits paid for you under the Policy reach the maximum amount payable as described herein.

[5. EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When does Spouse Insurance start?
Spouse Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

How can you make changes in Spouse Insurance?
You may request a decrease in your Spouse Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease the Spouse Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Spouse Insurance start?
Any reduction in your Spouse Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Spouse Insurance end?
Your Spouse Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- [the date your Spouse attains age [70];]
- the last day for which any required premium has been paid for your Spouse Insurance;
- the date you request in writing to end your Spouse Insurance;
- the date you reside outside the United States [or Canada];
- [the date you become insured again under the Qualifying Group Insurance Policy];
- the date all benefits paid for your Spouse under the Policy reach the maximum amount payable for your Spouse as described herein; and
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate.**]**

[[6.] EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

When does Dependent Children Insurance start?
Dependent Children Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

[How can you make changes in Dependent Children Insurance?
You may request a decrease in your Dependent Children Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease the Dependent Children Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Dependent Children Insurance start?
Any reduction in your Dependent Children Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Dependent Children Insurance end?
Your Dependent Children Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- the last day for which any required premium has been paid for your Dependent Children Insurance;
- the date you request in writing to end your Dependent Children Insurance;
- the date all benefits paid for you under the Policy reach the maximum amount payable as described herein;
- the date you reside outside the United States [or Canada];
- [the date you become insured again under the Qualifying Group Insurance Policy];
- for a specific Dependent Child, the date all benefits paid reach the maximum amount payable as described herein; and
- the date a Dependent Child no longer meets the definition of Dependent Child as described in this Certificate.**]**

[7.] PREMIUMS

When are your premiums due and how are they determined?
Your first premium is due on the Certificate Effective Date. Subsequent premiums are due on the Premium Due Date. Premiums are based upon the then current premium rates in effect for the benefits provided.

Premiums are payable to us at [our Executive Office] and will be paid in United States dollars [and Canadian dollars] [and Canadian dollars at the accepted daily rate of exchange], on the Premium Due Date.

Can premium rates that apply to your insurance change?
We determine initial and any subsequent premium rates. [We have the right to recalculate any premium rate after the initial premium rate has been in effect for [12 months].]

We will provide you written notice of any change in the premium rates at least [60] days prior to the effective date of the change.

What is the grace period?
The grace period is the [31-day] period of time following the Premium Due Date during which you may make an unpaid premium payment. If you do not pay the required premium before the end of the grace period, this Certificate will automatically terminate at the end of the grace period. Should any benefits become payable as a result of insurance provided during the grace period, we may deduct any premiums due from those benefits.

[8.] BENEFIT PROVISIONS

What benefits are payable?
We will pay you a lump-sum benefit for the insurance in force each time any eligible Insured, on or after the Certificate Effective Date:

- is Diagnosed with a Critical Illness condition[; or
- undergoes a Critical Illness procedure,]

as defined in the Covered Conditions section of this Certificate.

Any benefits payable are subject to the limitations, exclusions and other conditions stated in this Certificate.

How is the amount of the benefit determined?
We will multiply the Insured's Insurance Amount by the Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

[9.] COVERED CONDITIONS

What Critical Illness conditions are covered?
The Critical Illness conditions [and procedures] listed below are covered under the Policy.

[CIRCULATORY CONDITIONS CATEGORY

[**Heart Attack** means a confirmed Diagnosis of the death of heart muscle due to acute obstruction of a coronary artery that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction and includes at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a Heart Attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist Physician.

Exclusions:
Heart Attack does not include:
- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- silent myocardial infarction, including ECG or imaging changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.]

[Stroke (cerebrovascular accident) means a confirmed Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or cerebral embolism from an extra-cranial source, with:
- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination which persist for [30 days] following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The Diagnosis of Stroke must be made by a Specialist Physician.

Exclusions:
Stroke does not include any of the following:
- transient ischemic attacks;
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.**]**

[Heart Transplant means a confirmed Diagnosis of the irreversible failure of the heart and that transplant is medically necessary as soon as an appropriate donor is located. Heart Transplant under the Policy includes a procedure to replace the heart together with a lung, commonly referred to as a heart/lung transplant. To qualify under Heart Transplant, the Insured must be listed with the United Network of Organ Sharing (UNOS) on a Heart Transplant waiting list or have undergone a Heart Transplant as the recipient while insured under the Policy. The Diagnosis of the heart failure requiring Heart Transplant must be made by a Specialist Physician.]

[**Coronary Artery Bypass Surgery** means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-

catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a Specialist Physician.]

[**Aortic Surgery** means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist Physician.]

[**Coronary Artery Angioplasty** means the undergoing of balloon angioplasty, laser angioplasty, or atherectomy or the placement of a stent to correct narrowing or blockage of one or more coronary arteries. The Coronary Artery Angioplasty must be determined to be medically necessary by a Specialist Physician.]**]**

[CANCER CONDITIONS CATEGORY

Cancer means a confirmed Diagnosis of a tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist Physician.

A Clinical Diagnosis will be accepted only if:

- a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
- there is medical evidence to support the Diagnosis; and
- a Physician is treating you for Cancer.

In all other cases, Cancer must be Diagnosed with histopathological confirmation.

Exclusions:
Cancer does not include:

- carcinoma in situ;
- evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including, but not limited to, proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis; or
- any non-melanoma skin cancer that has not become metastasized.

No benefit will be payable under this provision for the Non-Life Threatening Cancers listed in the Non-Life Threatening Cancer provision below.

[No benefit will be payable for a recurrence or metastasis of an original Cancer which was Diagnosed prior to the effective date of insurance.]

[*Cancer Benefit Waiting Period:*
No benefit will be payable for Cancer and the Insured's insurance for Cancer and Non-Life Threatening Cancer will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the Insured's insurance; and
- the effective date of the Insured's insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of any cancer (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of any cancer (covered or excluded under this insurance).

Although the Insured's insurance for Cancer and Non-Life Threatening Cancer terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Cancer or Non-Life Threatening Cancer or any Critical Illness caused by any cancer or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Cancer Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Cancer Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Cancer Benefit Waiting Period. **]**

Non-Life Threatening Cancer is limited to the following:

- chronic lymphocytic leukemia that has not progressed beyond Rai stage 0;
- Stage 1A (T1a) malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion);
- Stage A (T1a or T1b) prostate cancer;
- papillary microcarcinoma of the thyroid, which for the purposes of the Policy means a papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid;
- noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0; and
- ductal carcinoma in situ (DCIS)of the breast.

Non-Life Threatening Cancer must be Diagnosed by a Specialist Physician with histopathological confirmation.

Exclusions:

Non-Life Threatening Cancer does not include any of the following:

- pre-malignant lesions;
- any carcinoma in situ except ductal carcinoma in-situ of the breast;
- evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

[No benefit will be payable for a recurrence or metastasis of an original Non-Life Threatening Cancer which was Diagnosed prior to the effective date of insurance.]

[*Non-Life Threatening Cancer Benefit Waiting Period:*

No benefit will be payable for Cancer and Non-Life Threatening Cancer and the Insured's insurance for Cancer and Non-Life Threatening Cancer will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the Insured's insurance; and
- the effective date of the Insured's insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of any cancer (covered or excluded under this insurance), regardless of when the Diagnosis is made; or
b. a Diagnosis of any cancer (covered or excluded under this insurance).

Although the Insured's insurance for Cancer or Non-Life Threatening Cancer terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Cancer or Non-Life Threatening Cancer or any Critical Illness caused by any cancer or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Non-Life Threatening Cancer Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Non-Life Threatening Cancer Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Non-Life Threatening Cancer Benefit Waiting Period.**]]**

[OTHER CONDITIONS CATEGORY

[Benign Brain Tumor means a confirmed Diagnosis of a non-malignant tumor located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumor must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumor must be made by a Specialist Physician.

Exclusions:
Benign Brain Tumor does not include pituitary adenomas less than 10 mm. in diameter.

[No benefit will be payable for a recurrence or metastasis of an original tumor which was diagnosed prior to the effective date of insurance.]

[*Benign Brain Tumor Benefit Waiting Period:*
No benefit will be payable for Benign Brain Tumor and the Insured's insurance for Benign Brain Tumor will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the person's insurance; and
- the effective date of the person's insurance,

the Insured has any of the following:
a. signs, symptoms or investigations, that lead to Diagnosis of Benign Brain Tumor (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of Benign Brain Tumor (covered or excluded under this insurance).

Although the Insured's insurance for Benign Brain Tumor terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Benign Brain Tumor or any Critical Illness caused by Benign Brain Tumor or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Benign Brain Tumor Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Benign Brain Tumor Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Benign Brain Tumor Benefit Waiting Period.**]]**

[**Coma** means a confirmed Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The Diagnosis of coma must be made by a Specialist Physician.

Exclusions:
Coma does not include any of the following:
- a medically induced coma; or
- a coma which results directly from alcohol or drug use.]

[**Major Organ Failure** means a confirmed Diagnosis by a Specialist Physician of the irreversible end-stage failure of bone marrow, kidney, liver or lung function, and:

- [for kidney failure only, dialysis (either hemo or peritoneal) is initiated;] or
- for all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Insured
  - is either listed with the United Network of Organ Sharing (UNOS); or
  - a suitable donor is found without a UNOS listing.

Proof of Major Organ Failure requires:

- submission of medical records documenting major organ failure from a Specialist Physician; and
- except for kidney failure on dialysis, documentation of either a
  - listing with the United Network of Organ Sharing (UNOS); or
  - documentation that a suitable donor has been found without a UNOS listing.

Major Organ Failure will be deemed to have occurred:

- [for kidney failure only, the date either dialysis is initiated,] or
- for all organs listed above, the date that the Insured
  - is either listed with the United Network of Organ Sharing (UNOS); or
  - a suitable donor is found without a UNOS listing.

Exclusions:
Major Organ Failure does not include any of the following:
- bone marrow failure that results from the treatment process for cancer;
- failure of any other organ not listed above; and
- autologous bone marrow transplant in which the Insured's own bone marrow is used.]

[**Paralysis** for the purposes of the Policy means total and irrecoverable loss of function of two or more limbs as a result of injury to or disease of the spinal cord. The loss must be present for a continuous period of at least [90 days] and be expected to be permanent. Limb is defined as the complete arm or the complete leg. The Diagnosis of paralysis must be made by a Specialist Physician.]

[**Severe Burns** means a confirmed Diagnosis of third-degree burns over at least 20% of the body surface. Severe Burns must occur while the Insured's insurance is in force to be eligible for a benefit. The Diagnosis of Severe Burns must be made by a Specialist Physician.]**]**

[CHILDHOOD CONDITIONS CATEGORY
The following covered childhood conditions apply only to children who meet the definition of Dependent Children and are insured under this Certificate:

[**Cerebral Palsy** means a confirmed Diagnosis of nonprogressive, neurological defect affecting muscle control. Diagnosis for Cerebral Palsy must be made by a Specialist Physician.]

[**Congenital Heart Disease** means a confirmed Diagnosis of at least one of the following covered heart conditions:

- coarctation of the aorta;
- Ebstein's anomaly;
- Eisenmenger syndrome;
- Tetralogy of Fallot;
- transposition of the great vessels; or
- any other congenital cardiac condition that requires life-saving surgery to survive.

It also means any one of the following specific conditions for which open heart surgery is performed to correct:

- aortic stenosis;
- atrial septal defect;
- discrete subvalvular aortic stenosis;
- pulmonary stenosis; or
- ventricular septal defect.

Exclusions:
Congenital Heart Disease does not include any of the following procedures:

- percutaneous atrial septal defect closure; or
- trans-catheter procedures which include balloon valvuloplasty.

The Diagnosis of Congenital Heart Disease must be made and the surgery must be recommended and performed by a Specialist Physician and supported by cardiac imaging acceptable to us.]

[**Cystic Fibrosis,** also known as mucoviscidosis, means the confirmed Diagnosis of a recessive genetic disease affecting most critically the lungs and also the pancreas, liver, and intestine. It is characterized by abnormal transport of chloride and sodium across the epithelium leading to thick viscous secretions. The Diagnosis of cystic fibrosis must be made by a Specialist Physician.]

[**Type 1 Diabetes Mellitus** means a confirmed Diagnosis where the Insured has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months. The Diagnosis of type 1 diabetes mellitus must be made by a Specialist Physician.]

[**Muscular Dystrophy** means a confirmed Diagnosis of one of a group of muscle diseases characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue. The confirmed Diagnosis of Muscular Dystrophy must be made by a Specialist Physician.]

[*Childhood Conditions Benefit Waiting Period:*
No benefit will be payable for any Childhood Condition and the Insured's insurance for such Childhood Condition will terminate if, within [30 days] following the effective date of the Dependent Child's insurance, the Dependent Child has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of such Childhood Condition (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of such Childhood Condition (covered or excluded under this insurance).

Although the Insured's insurance for such Childhood Condition terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for a Childhood Condition or any Critical Illness caused by a Childhood Condition or its Treatment.

The Childhood Conditions Benefit Waiting Period does not apply when newborn or newly adopted children are added to your Dependent Children Insurance.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Childhood Conditions Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Childhood Conditions Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Childhood Conditions Benefit Waiting Period.**]]**

[10.] LIMITATIONS AND EXCLUSIONS

What exclusions apply to the benefits payable?
In addition to the exclusions stated in the Covered Conditions section of this Certificate, we will not pay any benefit that is caused by, contributed to in any way, or resulting from any of the following:

- any Critical Illness condition Diagnosed outside the United States or Canada without confirmation of the Diagnosis by the type of Specialist Physician specified for each of the Covered Conditions in Section [9] who practices in the United States or Canada[; or
- any Critical Illness procedure performed outside the United States or Canada].

We will not pay a benefit for any Critical Illness that is due to or results from:

- intentionally self-inflicted injuries;
- elective plastic or cosmetic surgery;
- active military duty;
- participation in war, declared or undeclared, or any act of war;
- [active participation in a riot, rebellion or insurrection;]
- [committing or attempting to commit an assault, felony or other criminal act;]
- [engagement in scuba diving, parachuting, hang gliding, motorized racing, ballooning, kick-boxing, cliff diving, mountain climbing, powerboat racing, heli-skiing, big game hunting, cave exploration, extreme sports, underwater diving, rodeo events or white water rafting, where there is a likelihood of death or serious injury;]
- [being legally intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed; or]
- [improper or illegal use of inhalants or huffing].

What limitations apply to the benefits payable?
In addition to the limitations stated in the Covered Conditions section of this Certificate, we will not pay any benefit for any Critical Illness that is Diagnosed in the first [12 months] following the effective date of any Insured's insurance and results from a Pre-Existing Condition.

Pre-Existing Condition means during the [6 months] prior to any Insured's effective date of insurance, any condition for which any Insured:

- sought medical treatment, consultation, advice, care or services, including diagnostic measures for the condition, regardless of whether the condition was diagnosed or suspected at that time;
- took prescribed drugs or medicines for the condition[; or
- had symptoms for which an ordinarily prudent person would have consulted a health care provider for Diagnosis, care or Treatment].

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Pre-Existing Condition limitation toward the satisfaction of the period of time required by this Certificate's Pre-Existing Condition limitation.

What are the maximum benefits payable under this Certificate?
[We will only pay one benefit for each Covered Condition shown in the Benefit Highlights.] We will not pay more than an aggregate of [100%] of the benefits payable for all Covered Conditions in the same Category as shown in the Benefit Highlights. [We will not pay more than an aggregate of [200%] of the benefits payable for all the Covered Conditions in all Categories shown in the Benefit Highlights.]

[11.] CLAIMS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us written Notice and Proof of claim within the time limits specified.

NOTICE OF CLAIM

When does written Notice of Claim have to be submitted?
Written notice of claim must be given to us no later than [60 days] after the date of Diagnosis or within [90 days] of the Treatment of the Critical Illness.

If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

When we receive written notice of claim, we will send the forms for Proof of claim. If the forms are not received within 15 days after written notice of claim is sent, Proof of claim may be sent to us without waiting to receive the Proof of claim forms.

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PROOF OF CLAIM

When does written Proof of claim have to be submitted?
Proof of claim must be given to us no later than [120 days] after the date of Diagnosis or Treatment of the Critical Illness.

If Proof cannot be given within these time limits, Proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time Proof is otherwise required unless the individual is legally incompetent.

What is considered Proof of claim?
Proof of claim must consist of at least the following information:

- a description of the Critical Illness;
- the date the Diagnosis and/or Treatment occurred; and
- the cause of the Critical Illness.

Proof of claim may include, but is not limited to, police accident reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials, as required.

We may require as part of the Proof, authorizations to obtain medical and non-medical information. Proof must be satisfactory to us.

PAYMENT OF BENEFITS

When are benefits payable?
Benefits are payable upon our receipt of satisfactory Proof of claim that establishes benefit eligibility according to the provisions of this Certificate.

When will a decision on your claim be made?
We will send you a written notice of our decision on your claim within a reasonable time after we receive the claim but not later than [45 days] after receipt of the claim. If we cannot make a decision within [45 days] after receiving your claim, we will request a [30-day] extension as permitted by U.S. Department of

Labor regulations. If we cannot render a decision within the extension period, we will request an additional [30-day] extension. Any request for extension will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have [45 days] to provide the specified information.

What if your claim is denied?
If we deny all or any part of your claim, you will receive a written notice of denial setting forth:

- the specific reason(s) for the denial;
- the specific Certificate provision(s) on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- [your right to bring a civil action under ERISA, §502(a) following an adverse determination on review.]
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

Can you request a review of a claim denial?
If all or part of your claim is denied, you may request in writing a review of the denial within [180 days] after receiving notice of denial.

You may submit written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

We will review the claim on receipt of the written request for review, and will notify you of our decision within a reasonable time but not later than [45 days] after the request has been received. If an extension of time is required to process the claim, we will notify you in writing of the special circumstances requiring the extension and the date by which we expect to make a determination on review. The extension cannot exceed a period of [45 days] from the end of the initial period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have at least [45 days] to provide the specified information.

What if your claim is denied on review?
If we deny all or any part of your claim on review, you will receive a written notice of denial setting forth:

- the specific reasons for the denial;
- the specific Certificate provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- [your right to bring a civil action under ERISA, §502(a);]

- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request;
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency."; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the appeal, regardless of whether the advice was relied upon to deny the appeal.

To whom are benefits payable?
We will pay you all benefits, if your Proof of claim is satisfactory to us, except in the following situations:

1. You are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons;
2. Due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described in item 1; or
3. You die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay to such person or persons.

If we do not pay you and claim is not made by the appropriate person designated above, we may make payments under either or both Methods A or B below. We may decide to pay any benefits, prior to the appointment of the appropriate person designated in items [1, 2, or 3 above], and/or we may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

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Method A: We may pay up to the sum of [$5,000] to any individual or entity that has provided Proof of having incurred or paid expenses as a result of funeral services provided to or on your behalf. If we pay such a benefit, we will not have to pay that benefit amount again and the total benefit due under this Certificate shall be reduced by the amount paid under this provision.

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Method B: We may pay the whole or any part of such benefit:
- to your lawful spouse, up to a cumulative amount of [$5,000]; or
- if you have no lawful spouse, up to a cumulative amount of [$5,000] to any one or more of the following relatives in the following order of priority:

    1. your child or children; or
    2. your mother or father.

[12.] GENERAL PROVISIONS

ALTERATION

Who can alter this Certificate?
The only persons with the authority to alter or modify this Certificate or to waive any of its provisions are our president, actuary, secretary or one of our vice presidents and any such changes must be in writing.

[ASSIGNMENT

Can benefits be assigned?
You cannot assign any interest in this Certificate unless we agree in writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by us will discharge our liabilities under this Certificate, to the extent of such payments.]

CLERICAL ERROR

What happens when there is a clerical error in the administration of this Certificate**?**
Clerical errors in connection with this Certificate or delays in keeping records for this Certificate whether by us or the Policyholder:

- will not terminate insurance that would otherwise have been effective.
- will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error, subject to the "Limit of Premium Refunds" section.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of this Certificate conflicts with any applicable law, the provisions of this Certificate will be automatically amended to meet the minimum requirements of the law and to reflect updated statutory references.

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under this Certificate?
Payment made under the terms of this Certificate will, to the extent of such payment, release us from all further obligations under this Certificate. We will not be obligated to see to the application of such payment.

EXAMINATION

What are our examination rights?
We, at our own expense, have the right to have any person whose Critical Illness is the basis of a claim:

- examined by a Physician, Specialist Physician, other health professional or vocational expert of our choice; and/or

- interviewed by an authorized representative.

This right may be used as often as reasonably required.

INCONTESTABILITY

What is Incontestability?
Except for non-payment of premium, any claims incurred within two years of the effective date of an Insured's initial or reinstated insurance or as otherwise stated in this provision, we cannot contest the validity of such insurance regarding any Insured after it has been in force during the lifetime of such Insured for a period of two years from the Certificate Effective Date.

Additionally, for any insurance provided under the Policy that results from a statement of insurability submitted under the Qualifying Group Insurance Policy, except for any claims incurred before that insurance has been in force under the Qualifying Group Insurance Policy and this Policy for an aggregate period of two years during the insured's lifetime, measured from the effective date of the insurance for which the statement was provided, we cannot contest the validity of such insurance based on that statement.

This provision shall not preclude the assertion at any time of a defense to a claim based upon the Insured's eligibility for insurance.

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of this Certificate?
If relevant facts about the Participant relating to this insurance are not accurate:

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the true facts will decide whether, and in what amount, and for what duration insurance is valid under this Certificate.

NON-PARTICIPATING

Does this Certificate participate in dividends?
This Certificate is non-participating and will not share in any profits or surplus earnings of Sun Life Assurance Company of Canada, and, therefore, no dividends are payable.

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INSURER'S AUTHORITY ¶
¶
What is our authority?¶
We have discretionary authority to make all final determinations regarding claims for benefits. This discretionary authority includes, but is not limited to, the determination of eligibility for benefits, based upon enrollment information provided by the policyholder of the Qualifying Group Insurance Policy, and the amount of any benefits due, and to construe the terms of the Policy.¶
¶
Any decision made by us in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing our determinations shall uphold such determination unless the claimant proves that our determinations are arbitrary and capricious.¶
¶
¶

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?
No legal action may start:

- until [60 days] after Proof has been given; nor
- more than [3 years] after the time Proof of claim is required.

LIMIT OF PREMIUM REFUNDS

Is there a limit on premium refunds?
Whether premiums were paid in error or otherwise, we will refund only that part of the excess premium that was paid during the [12-month] period that preceded the date we learned of such overpayment.

NOTICE

How are required notices provided?
Any obligation we may have to give written notice will be satisfied by sending such notice to the last known address of the person or institution entitled to such notice.

PREMIUM PAYMENTS AS EVIDENCE OF INSURANCE

Does the payment of premiums guarantee coverage under the Policy?
The receipt of premiums by us is not a guarantee of insurance. Eligibility for benefits will be determined at the time of claim submission and all Policy requirements must be satisfied.

REIMBURSEMENT

What if a benefit is underpaid or overpaid?
Reimbursement will be made to us for any overpayments that we may make due to any reason. You must repay us within 60 days unless we agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If we have underpaid a benefit for any reason, we will make a lump sum payment for that amount.

Interest does not accrue on any underpaid or overpaid benefit unless required under the applicable law.

STATEMENTS

Are statements warranties?
In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by you in enrolling for insurance under the Policy will be used to reduce or deny a claim unless a copy of your written application for insurance is or has been given to you, your beneficiary, if any, or to your estate representative.

TIME PERIODS

What time periods apply to this Certificate?
For the purpose of effective dates and termination dates under this Certificate, all days begin at 12:00 midnight and end at 11:59:59 PM at the Participant's location.

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Critical Illness Insurance Certificate
[Critical Illness and Cancer]

Non-Participating

Sun Life Assurance Company of Canada

Portability Application – [Disability] [and] [Critical Illness]

Please complete the sections indicated below, read the fraud warnings and acknowledgement, and sign and date the form. Mail the completed form, a copy of your Portability Notice, and a check for the first premium to Sun Life Assurance Company of Canada. Questions about portability? Please call 1-800-247-6875.

I am applying for Portable:

[☐ Disability insurance (complete sections 1, [2.1], 3 and 5)]

[☐ Critical Illness insurance (complete sections 1, [2.2], 3 and 5)]

1 General information

Your name (first, middle initial, last)			Date of birth (m/d/y)
Residence address (street number & name, apartment or suite)	City	State	Zip
Social Security number [ ]	Home phone number	Alternate phone number	

Information about the qualifying group policy(ies)

Name of group policyholder (i.e., your employer or plan administrator)	Policy number(s)

2 Coverage amount information

[[2.1] Disability insurance coverage amount

See section [3] of the Portability Notice for the amount of insurance you are eligible to apply for. You may apply for coverage only if your employer's plan includes this option. You may elect to keep the current amount(s) of disability coverage you had with your prior employer or elect a lower amount. Check one box for each coverage you are requesting to port and write in the amount elected.

[Short-Term Disability ☐ Elect to keep current amount ☐ Elect a lower amount	Amount elected $]
[Long-Term Disability ☐ Elect to keep current amount ☐ Elect a lower amount	Amount elected $]
[Customized Disability insurance ☐ Elect to keep current amount ☐ Elect a lower amount	Amount elected $]

]

[2 Coverage amount information, continued]

[[2.2] Critical Illness insurance coverage amount]

See section [3] of the Portability Notice for the amount of insurance you are eligible to apply for. You may apply for Critical Illness coverage only if your employer's plan includes this option. You may elect to keep the current amount(s) of Critical Illness coverage you had with your prior employer, or elect a lower amount. Check one box for each coverage you are requesting to port and write in the amount elected.

NOTE: Any reference to spouse used below includes your civil union partner.

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You may only port spouse/child benefits if you are electing to port your employee benefits and if your spouse/child were insured under the group policy at the time of your termination. Under limited conditions, spouses may be eligible to apply for portable spouse/child insurance. Contact us at the number shown above for details.

[Employee Critical Illness Only insurance	**[Employee Critical Illness and Cancer insurance**	**[Employee Critical Illness, Cancer Only insurance**
☐ Elect to keep current amount ☐ Elect a lower amount	☐ Elect to keep current amount ☐ Elect a lower amount	☐ Elect to keep current amount ☐ Elect a lower amount
Amount elected $]	Amount elected $]	Amount elected $]

[Spouse Critical Illness Only insurance	**[Spouse Critical Illness and Cancer insurance**	**[Spouse Critical Illness, Cancer Only insurance**
☐ Elect to keep current amount ☐ Elect a lower amount	☐ Elect to keep current amount ☐ Elect a lower amount	☐ Elect to keep current amount ☐ Elect a lower amount
Amount elected $]	Amount elected $]	Amount elected $]

[Child Critical Illness Only insurance	**[Child Critical Illness and Cancer insurance**	**[Child Critical Illness, Cancer Only insurance**
☐ Elect to keep current amount ☐ Elect a lower amount	☐ Elect to keep current amount ☐ Elect a lower amount	☐ Elect to keep current amount ☐ Elect a lower amount
Amount elected $]	Amount elected $]	Amount elected $]

If you have elected spouse and/or child(ren) coverage above, be sure to write in the spouse/child(ren) name(s) and date(s) of birth.

Spouse name (first, middle initial, last)	Social Security number [ ]	Date of birth (m/d/y)
Child name (first, middle initial, last)	Social Security number [ ]	Date of birth (m/d/y)
Child name (first, middle initial, last)	Social Security number [ ]	Date of birth (m/d/y)

If you need additional space, check here ☐ and attach a separate sheet.]

3 Premium information

Premium payment

Amount enclosed	How would you prefer to pay premiums?
$	☐ Annually ☐ Semi-annually ☐ Quarterly

4 Fraud warnings

[General fraud warning: Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[For AL the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.]

4 Fraud warnings, continued

[For AR, LA, MA, NM, RI, and WV, the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For CO the following warning applies: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.]

[For the District of Columbia the following notice applies: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For FL the following notice applies: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[For KS the following notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.]

[For KY the following notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.]

[For MD the following notice applies: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For ME, TN, VA, and WA the following notice applies: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

[For NJ the following notice applies: Any person who knowingly includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[For OH the following notice applies: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud**.]**

[For OK the following notice applies: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[For OR the following notice applies: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

[For PR the following notice applies: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.]

5 Acknowledgment and signature

To begin processing your request for portability coverage, Sun Life Assurance Company of Canada must receive this signed Application form, any other required documentation, and your first premium within [31] days of your termination date.

No insurance requested in this Application form will become effective until Sun Life Assurance Company of Canada accepts the Application, notifies you of its acceptance, and receives the first premium payment from you. If you submit the initial premium payment with the Application and Sun Life rejects the Application, Sun Life will refund the premium. If your Application is accepted, Sun Life will bill you for future premium payments. Rates will increase when you reach a new age band and may increase for reasons other than age. See the Portability Kit or ask your employer for rates and age bands.

You must read and sign to apply for coverage.
I/We understand and agree that: (1) My/Our eligibility for Portable Group Insurance will be based on the Portability conditions stated in the qualifying group policy(ies). (2) The answers and statements in this Application will be the basis for and become part of any insurance certificate issued as a result of this Application. (3) The certificate issued will replace the coverage provided by the group policy indicated in section 1 of this Application. (4) No insurance requested in this Application will be effective until Sun Life Assurance Company of Canada accepts this Application and receives my initial premium payment. (5) A claim may be denied in accordance with the Incontestability provision of the Portability Certificate if the statements in this Application are not complete and true. (6) All portable insurance will be subject to the terms and conditions of the Portable Group Insurance Certificate and the Group Policy under which it is issued.

Signature of employee X	Date

[(Employee's signature is not required above if spouse is porting due to divorce or death of the employee.)]

[Signature of spouse (if also applying for Critical Illness coverage)] X	Date

Contact us

By mail
Sun Life Assurance Company of Canada
[One Sun Life Executive Park], [SC 3015]
Wellesley Hills, MA 02481

[www.sunlife.com/us]

Customer Service [**800-247-6875]** M–F [8:30 a.m. – 6:00 p.m., ET]

SERFF Tracking #:	*SNLF-128701171*	***State Tracking #:***		***Company Tracking #:***	*2012 CRITICAL ILLNESS-CANCER PORTABILITY*

State:	*Arkansas*	***Filing Company:***	*Sun Life Assurance Company of Canada*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*2012 Critical Illness-Cancer Portability*		
Project Name/Number:	*2012 Critical Illness-Cancer Portability/2012 Critical Illness-Cancer Portability*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/02/2012	Replaced 12/03/2012	Form	Critical Illness/Cancer Portability Certificate	11/15/2012	12-SDPort-C-01 - AR - Critical Illness Portability 9-27-12.pdf (Superceded)
10/02/2012	Replaced 12/03/2012	Supporting Document	Statements of Variability	11/15/2012	GMPAP-2548 - SoV - 9-27-12.pdf (Superceded) 12-SDPort-C-01 - AR - SOV - 9-27-2012.pdf (Superceded)
10/02/2012	Replaced 12/03/2012	Form	Portability Application	11/15/2012	GMPAP-2548 - Portability Application - 9-27-12.pdf (Superceded)
10/02/2012	Replaced 12/03/2012	Form	Critical Illness/Cancer Portability Certificate	10/02/2012	12-SDPort-C-01 - AR - Critical Illness Portability 9-27-12.pdf (Superceded)

SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
[One Sun Life Executive Park]
[Wellesley Hills, MA 02481]

[(800) 247-6875]
[www.sunlife.com/us]

Sun Life Assurance Company of Canada certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

Policy Number:	[00000001]
Policy Effective Date:	[September 1, 2012]
Policyholder:	[ABC Trust]
Certificate Number:	[12345]
Certificate Effective Date:	[September 1, 2012]
Issue State:	[Massachusetts]

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

This Certificate contains the terms of the Group Insurance Policy that affect your insurance. This Certificate is part of the Group Insurance Policy.

This Certificate is governed by the laws of the Issue State shown above.

Signed at Wellesley Hills, Massachusetts.

[Dean A. Connor]
[President and Chief Executive Officer]

[Dana J. Easthope]
[Vice-President, Associate General Counsel and Corporate Secretary]

Group Critical Illness Insurance Certificate
[Critical Illness and Cancer]

Non-Participating

Sun
[Life Financial[SM]]

NOTICE TO CERTIFICATEHOLDER

THIS NOTICE IS TO ADVISE YOU THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING YOUR SUNLIFE GROUP INSURANCE PLAN, YOU MAY CONTACT THE FOLLOWING:

SUN LIFE ASSURANCE COMPANY OF CANADA
[GROUP CUSTOMER SERVICE CENTER SC1219
U.S. HEADQUARTERS OFFICE
ONE SUN LIFE EXECUTIVE PARK
WELLESLEY HILLS, MA 02481
(800) 247-6875

ALSO AVAILABLE TO YOU IS THE CONSUMER SERVICES DIVISION OF THE ARKANSAS INSURANCE DEPARTMENT, [1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS 72201-1904, (501) 371-2640 or (800) 852-5494]

TABLE OF CONTENTS

1. BENEFIT HIGHLIGHTS

Participant: **John Doe**

[Premium Due Date: [The first day of each month] **]**

Insurance Amounts

[Participant Insurance Amount:	[$100,000] [Change Increment Amount: [$5,000]] Minimum: [$5,000]
Insured: [John Doe] **]**	
[Spouse Insurance Amount:	[$100,000] [Change Increment Amount: [$5,000]] Minimum: [$5,000]
Insured: [Jane Doe] **]**	
[Dependent Children Insurance:	[Change Increment Amount: [$5,000]] Minimum: [$5,000]
Insured: [Bill Doe]	[$100,000]
[Insured: [Bob Doe]]	[$100,000] **]**

[Circulatory Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Heart Attack	[100%]]
[Stroke	[100%]]
[Heart Transplant	[100%]]
[Coronary Artery Bypass Surgery	[25%]]
[Aortic Surgery	[25%]]
[Coronary Artery Angioplasty	[25%]] **]**

[Cancer Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Cancer	[100%]]
[Non-Life Threatening Cancer	[25%]] **]**

[Other Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Benign Brain Tumor	[100%]]
[Coma	[100%]]
[Major Organ Failure	[100%]]
[Paralysis	[100%]]
[Severe Burns	[100%]] **]**

[Childhood Conditions Category - [Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Cerebral Palsy	[100%]]
[Congenital Heart Disease	[100%]]
[Cystic Fibrosis	[100%]]
[Type 1 Diabetes Mellitus	[100%]]
[Muscular Dystrophy	[100%]] **]**

Maximum Benefits Payable for each Insured under this Certificate:

- We will only pay one benefit for each Covered Condition shown above;
- We will not pay more than an aggregate of [100%] of the benefit payable for Covered Conditions in the same Category**[**; and
- We will not pay more than an aggregate of [200%] of the benefit payable for all the Covered Conditions in all Categories shown above].

Note: All benefits available for Covered Conditions under this portability Certificate will be reduced by any benefits paid or payable under the Qualifying Group Insurance Policy. The Maximum Benefits available under this Certificate shall be reduced by any benefits paid or payable under the Qualifying Group Insurance Certificate.

2. DEFINITIONS

Benefit Percentage means the percentage that is applied to your Insurance Amount to determine the amount of Critical Illness benefits payable under the Policy.

[**Clinical Diagnosis** means a Diagnosis of Cancer based on observation and history, diagnostic and laboratory studies, and symptoms.]

Critical Illness means only the illnesses [or procedures] defined in the Covered Conditions section of this Certificate for which benefits are payable.

[Dependent Child means the Participant's:

- [[unmarried] child from live birth to under age [26] [who is enrolled as a full time student and depends on the Participant for [50%] or more of the child's support.]]

Dependent Child includes:

- **[**a Participant's [unmarried] step-child];
- [a child for whom the Participant has legal guardianship];
- [a foster child placed with the Participant by a licensed agency];
- a Participant's adopted child, including any child placed with the Participant for adoption;

[If [an] [unmarried] child is age [26] or older and is:

- **[**incapable of self-sustaining employment because of a mental retardation, developmental disability or physical handicap]; [and
- dependent on the Participant for **[**[50%] or more of his/her**]** support;**]**

that child will continue to be a Dependent under the Policy for as long as these conditions exist.**]**

[No person may be considered to be a Dependent Child of more than one Participant.]

Dependent Child does not include:

- **[**any person who is insured as a Participant; or]
- any person residing outside the [United States], [Canada], or [Mexico]. [This exclusion does not apply to a Dependent Child who resides with a Participant who is on a temporary work assignment outside the [United States].**]**

Diagnosis (Diagnosed) means a definitive identification of the Critical Illness made during the lifetime of the Insured by a Specialist Physician:

- supported by documentation of all appropriate and defined studies;
- based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
- meeting any diagnostic requirements stated in this Certificate for the particular Critical Illness being diagnosed.

[**Divorce** means the dissolution of any relationship identified in the Marriage definition and the term "divorce decree" means the court-issued document appropriate for the termination of such a relationship.]

Insurance Amount means the amount of insurance available under the Policy as shown in the Benefit Highlights and for which a person covered under the Policy is insured.

Insured means any person covered under the Policy as named in the Benefit Highlights.

[Marriage means any of the following relationships recognized under applicable state law: a same-sex or opposite-sex marriage; a civil union partnership under which the partners have the same legal rights and

responsibilities as a married couple; [and a same-sex or opposite-sex registered domestic partnership under which the partners have the same legal rights and responsibilities as a married couple.]**]**

Participant means a person who was insured under a Qualifying Group Insurance Policy and who applied for insurance under the Policy. The Participant eligible for insurance under this Certificate is shown in the Benefit Highlights.

Physician means an individual who is operating within the scope of his or her license and is either:

- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

The Physician cannot be you, a business associate or any family member. “Family member” means: (a) your spouse and (b) the following relatives of you or your spouse: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Policy means the group insurance policy under which this Certificate is issued.

Proof means any medical, financial, or other information that is required under by us and is satisfactory to us.

Qualifying Group Insurance Policy means the group insurance policy we issued which included the portability option to apply for insurance under the Policy.

Specialist Physician means a medical doctor who is licensed and practicing in the United States or Canada and who has completed an accredited specialty training program recognized by the American Board of Medical Specialties and has passed the examination leading to Board Certification in the field most applicable to the condition being evaluated or equivalent certification acceptable to us.

[Spouse means any individual who under applicable state law is either recognized as a spouse, partner to a civil union[, a partner to a registered domestic partnership] under which the partners have the same legal rights and responsibilities as a married couple, or are otherwise accorded the same rights as a spouse.

Spouse does not include any person residing outside the [United States], [Canada], or [Mexico]. [This exclusion does not apply to a Spouse who resides with a Participant who is on a temporary work assignment outside the [United States].] **]**

Treatment means a Physician's consultation, care or services; diagnostic measures; or the prescription, refill or taking of prescribed drugs or medicines.

We, Us, Our (we, us, our) means Sun Life Assurance Company of Canada.

You, Your (you, your) means the Participant who is eligible for insurance under this Certificate.

3. PORTABILITY

When are you eligible for portability insurance?
You are eligible under the Qualifying Group Insurance Policy to elect to continue your insurance for up to [60 months] if all of the following requirements are met:

- [you have been validly Insured under the Qualifying Group Insurance Policy for at least [36 consecutive months];]
- your insurance ends because you terminate employment for reasons other than [leave of absence, labor strike, retirement, sickness or injury];
- the Qualifying Group Insurance Policy is still in force;
- you reside in the United States [or Canada];
- [you have not exercised your portability right under a similar certificate issued by us;] and
- you are under age [70] at the time employment terminates.

Your new portability insurance is provided by this Certificate. Your new portability insurance may not be identical to your current insurance under the Qualifying Group Insurance Policy.

What is the amount of portable insurance?
You may apply for portable insurance in an amount up to [100%] of each Insured's remaining amount of insurance validly in force under the Qualifying Group Insurance Policy on the date your insurance terminates. In no instance will the insurance issued under this Certificate be greater than the remaining amount of insurance in force under the Qualifying Group Insurance Policy on the date such insurance terminates. Your new portability insurance policy will not provide any benefits beyond those described in this Certificate.

When does your portable insurance start?
After your insurance under the Qualifying Group Insurance Policy terminates, your portable insurance provided by this Certificate starts on the later of the following:

- the date we approve your application for portable insurance; and
- the date we receive your first premium payment for portable insurance.

[When is portability available to the Spouse and when is the Spouse eligible?
Portability is available for the Spouse under the Qualifying Group Insurance Policy for up to [60 months] if all of the following requirements are met:

- the employee under the Qualifying Group Insurance Policy [dies] [or Divorces their Spouse];
- **[**the employee under the Qualifying Group Insurance Policy had been Insured under the Policy for at least [36 consecutive months];**]**
- the Qualifying Group Insurance Policy is still in force;
- the Spouse resides in the United States [or Canada]; and
- the Spouse is under age [70] at the time of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy.

The Spouse's new portability insurance is provided by this Certificate. Their new portability insurance may not be identical to the insurance under the Qualifying Group Insurance Policy.

What is the amount of the Spouse's portable insurance?
The Spouse may apply for portable insurance in an amount up to [100%] of the remaining amount of [Spouse Insurance] [and Dependent Children Insurance] in force under the Qualifying Group Insurance Policy on the date of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy. In no instance will the [Spouse Insurance] [and Dependent Children Insurance] issued under this Certificate be greater than the remaining amount of [Spouse Insurance] [and Dependent Children Insurance] in force under the Qualifying Group Insurance Policy on the date of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy. The Spouse's new portability insurance policy will not provide any benefits beyond those described in this Certificate.

[The Spouse may not apply for portable insurance for a Dependent Child whose insurance has not terminated under the Qualifying Group Insurance Policy due to Divorce.]

When does the Spouse's portable insurance start?
After the [Death] [or Divorce] of the employee under the Qualifying Group Insurance Policy, the Spouse's portable insurance will start on the later of the following:

- the date we approve the Spouse's application for portable insurance; and
- the date we receive the Spouse's first premium payment for portable insurance.**]**

4. EFFECTIVE DATES AND TERMINATION OF PARTICIPANT INSURANCE

When does Participant Insurance start?
Participant Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

How can you make changes in Participant Insurance?
You may request a decrease in your Participant Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease your Participant Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Participant Insurance start?
Any reduction in your Participant Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Participant Insurance end?
Your Participant Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- [the date you attain age [70];]
- the last day for which any required premium has been paid for your Participant Insurance;
- the date you request in writing to end your Participant Insurance;
- [the date you reside outside the United States [or Canada;]
- [the date you become insured again under the Qualifying Group Insurance Policy;] or
- the date all benefits paid for you under the Policy reach the maximum amount payable as described herein.

[5. EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When does Spouse Insurance start?
Spouse Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

How can you make changes in Spouse Insurance?
You may request a decrease in your Spouse Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease the Spouse Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Spouse Insurance start?
Any reduction in your Spouse Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Spouse Insurance end?
Your Spouse Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- [the date your Spouse attains age [70];]
- the last day for which any required premium has been paid for your Spouse Insurance;
- the date you request in writing to end your Spouse Insurance;
- the date you reside outside the United States [or Canada];
- [the date you become insured again under the Qualifying Group Insurance Policy];
- the date all benefits paid for your Spouse under the Policy reach the maximum amount payable for your Spouse as described herein; and
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate.**]**

[[6.] EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

When does Dependent Children Insurance start?
Dependent Children Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

[How can you make changes in Dependent Children Insurance?
You may request a decrease in your Dependent Children Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease the Dependent Children Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Dependent Children Insurance start?
Any reduction in your Dependent Children Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Dependent Children Insurance end?
Your Dependent Children Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- the last day for which any required premium has been paid for your Dependent Children Insurance;
- the date you request in writing to end your Dependent Children Insurance;
- the date all benefits paid for you under the Policy reach the maximum amount payable as described herein;
- the date you reside outside the United States [or Canada];
- [the date you become insured again under the Qualifying Group Insurance Policy];
- for a specific Dependent Child, the date all benefits paid reach the maximum amount payable as described herein; and
- the date a Dependent Child no longer meets the definition of Dependent Child as described in this Certificate.**]**

[7.] PREMIUMS

When are your premiums due and how are they determined?
Your first premium is due on the Certificate Effective Date. Subsequent premiums are due on the Premium Due Date. Premiums are based upon the then current premium rates in effect for the benefits provided.

Premiums are payable to us at [our Executive Office] and will be paid in United States dollars [and Canadian dollars] [and Canadian dollars at the accepted daily rate of exchange], on the Premium Due Date.

Can premium rates that apply to your insurance change?
We determine initial and any subsequent premium rates. [We have the right to recalculate any premium rate after the initial premium rate has been in effect for [12 months].]

We will provide you written notice of any change in the premium rates at least [60] days prior to the effective date of the change.

What is the grace period?
The grace period is the [31-day] period of time following the Premium Due Date during which you may make an unpaid premium payment. If you do not pay the required premium before the end of the grace period, this Certificate will automatically terminate at the end of the grace period. Should any benefits become payable as a result of insurance provided during the grace period, we may deduct any premiums due from those benefits.

[8.] BENEFIT PROVISIONS

What benefits are payable?
We will pay you a lump-sum benefit for the insurance in force each time any eligible Insured, on or after the Certificate Effective Date:

- is Diagnosed with a Critical Illness condition[; or
- undergoes a Critical Illness procedure,]

as defined in the Covered Conditions section of this Certificate.

Any benefits payable are subject to the limitations, exclusions and other conditions stated in this Certificate.

How is the amount of the benefit determined?
We will multiply the Insured's Insurance Amount by the Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

[9.] COVERED CONDITIONS

What Critical Illness conditions are covered?
The Critical Illness conditions [and procedures] listed below are covered under the Policy.

[CIRCULATORY CONDITIONS CATEGORY

[**Heart Attack** means a confirmed Diagnosis of the death of heart muscle due to acute obstruction of a coronary artery that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction and includes at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a Heart Attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist Physician.

Exclusions:
Heart Attack does not include:
- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- silent myocardial infarction, including ECG or imaging changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.]

[Stroke (cerebrovascular accident) means a confirmed Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or cerebral embolism from an extra-cranial source, with:
- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination which persist for [30 days] following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The Diagnosis of Stroke must be made by a Specialist Physician.

Exclusions:
Stroke does not include any of the following:
- transient ischemic attacks;
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.**]**

[Heart Transplant means a confirmed Diagnosis of the irreversible failure of the heart and that transplant is medically necessary as soon as an appropriate donor is located. Heart Transplant under the Policy includes a procedure to replace the heart together with a lung, commonly referred to as a heart/lung transplant. To qualify under Heart Transplant, the Insured must be listed with the United Network of Organ Sharing (UNOS) on a Heart Transplant waiting list or have undergone a Heart Transplant as the recipient while insured under the Policy. The Diagnosis of the heart failure requiring Heart Transplant must be made by a Specialist Physician.]

[**Coronary Artery Bypass Surgery** means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-

catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a Specialist Physician.]

[**Aortic Surgery** means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist Physician.]

[**Coronary Artery Angioplasty** means the undergoing of balloon angioplasty, laser angioplasty, or atherectomy or the placement of a stent to correct narrowing or blockage of one or more coronary arteries. The Coronary Artery Angioplasty must be determined to be medically necessary by a Specialist Physician.]**]**

[CANCER CONDITIONS CATEGORY

Cancer means a confirmed Diagnosis of a tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist Physician.

A Clinical Diagnosis will be accepted only if:

- a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
- there is medical evidence to support the Diagnosis; and
- a Physician is treating you for Cancer.

In all other cases, Cancer must be Diagnosed with histopathological confirmation.

Exclusions:
Cancer does not include:

- carcinoma in situ;
- evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including, but not limited to, proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis; or
- any non-melanoma skin cancer that has not become metastasized.

No benefit will be payable under this provision for the Non-Life Threatening Cancers listed in the Non-Life Threatening Cancer provision below.

[No benefit will be payable for a recurrence or metastasis of an original Cancer which was Diagnosed prior to the effective date of insurance.]

[*Cancer Benefit Waiting Period:*
No benefit will be payable for Cancer and the Insured's insurance for Cancer and Non-Life Threatening Cancer will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the Insured's insurance; and
- the effective date of the Insured's insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of any cancer (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of any cancer (covered or excluded under this insurance).

Although the Insured's insurance for Cancer and Non-Life Threatening Cancer terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Cancer or Non-Life Threatening Cancer or any Critical Illness caused by any cancer or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Cancer Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Cancer Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Cancer Benefit Waiting Period. **]**

Non-Life Threatening Cancer is limited to the following:

- chronic lymphocytic leukemia that has not progressed beyond Rai stage 0;
- Stage 1A (T1a) malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion);
- Stage A (T1a or T1b) prostate cancer;
- papillary microcarcinoma of the thyroid, which for the purposes of the Policy means a papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid;
- noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0; and
- ductal carcinoma in situ (DCIS)of the breast.

Non-Life Threatening Cancer must be Diagnosed by a Specialist Physician with histopathological confirmation.

Exclusions:

Non-Life Threatening Cancer does not include any of the following:

- pre-malignant lesions;
- any carcinoma in situ except ductal carcinoma in-situ of the breast;
- evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

[No benefit will be payable for a recurrence or metastasis of an original Non-Life Threatening Cancer which was Diagnosed prior to the effective date of insurance.]

[*Non-Life Threatening Cancer Benefit Waiting Period:*

No benefit will be payable for Cancer and Non-Life Threatening Cancer and the Insured's insurance for Cancer and Non-Life Threatening Cancer will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the Insured's insurance; and
- the effective date of the Insured's insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of any cancer (covered or excluded under this insurance), regardless of when the Diagnosis is made; or
b. a Diagnosis of any cancer (covered or excluded under this insurance).

Although the Insured's insurance for Cancer or Non-Life Threatening Cancer terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Cancer or Non-Life Threatening Cancer or any Critical Illness caused by any cancer or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Non-Life Threatening Cancer Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Non-Life Threatening Cancer Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Non-Life Threatening Cancer Benefit Waiting Period.**]]**

[OTHER CONDITIONS CATEGORY

[Benign Brain Tumor means a confirmed Diagnosis of a non-malignant tumor located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumor must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumor must be made by a Specialist Physician.

Exclusions:
Benign Brain Tumor does not include pituitary adenomas less than 10 mm. in diameter.

[No benefit will be payable for a recurrence or metastasis of an original tumor which was diagnosed prior to the effective date of insurance.]

[*Benign Brain Tumor Benefit Waiting Period:*
No benefit will be payable for Benign Brain Tumor and the Insured's insurance for Benign Brain Tumor will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the person's insurance; and
- the effective date of the person's insurance,

the Insured has any of the following:
a. signs, symptoms or investigations, that lead to Diagnosis of Benign Brain Tumor (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of Benign Brain Tumor (covered or excluded under this insurance).

Although the Insured's insurance for Benign Brain Tumor terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Benign Brain Tumor or any Critical Illness caused by Benign Brain Tumor or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Benign Brain Tumor Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Benign Brain Tumor Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Benign Brain Tumor Benefit Waiting Period.**]]**

[**Coma** means a confirmed Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The Diagnosis of coma must be made by a Specialist Physician.

Exclusions:
Coma does not include any of the following:
- a medically induced coma; or
- a coma which results directly from alcohol or drug use.]

[**Major Organ Failure** means a confirmed Diagnosis by a Specialist Physician of the irreversible end-stage failure of bone marrow, kidney, liver or lung function, and:

- [for kidney failure only, dialysis (either hemo or peritoneal) is initiated;] or
- for all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Insured
  - is either listed with the United Network of Organ Sharing (UNOS); or
  - a suitable donor is found without a UNOS listing.

Proof of Major Organ Failure requires:

- submission of medical records documenting major organ failure from a Specialist Physician; and
- except for kidney failure on dialysis, documentation of either a
  - listing with the United Network of Organ Sharing (UNOS); or
  - documentation that a suitable donor has been found without a UNOS listing.

Major Organ Failure will be deemed to have occurred:

- [for kidney failure only, the date either dialysis is initiated,] or
- for all organs listed above, the date that the Insured
  - is either listed with the United Network of Organ Sharing (UNOS); or
  - a suitable donor is found without a UNOS listing.

Exclusions:
Major Organ Failure does not include any of the following:
- bone marrow failure that results from the treatment process for cancer;
- failure of any other organ not listed above; and
- autologous bone marrow transplant in which the Insured's own bone marrow is used.]

[**Paralysis** for the purposes of the Policy means total and irrecoverable loss of function of two or more limbs as a result of injury to or disease of the spinal cord. The loss must be present for a continuous period of at least [90 days] and be expected to be permanent. Limb is defined as the complete arm or the complete leg. The Diagnosis of paralysis must be made by a Specialist Physician.]

[**Severe Burns** means a confirmed Diagnosis of third-degree burns over at least 20% of the body surface. Severe Burns must occur while the Insured's insurance is in force to be eligible for a benefit. The Diagnosis of Severe Burns must be made by a Specialist Physician.]**]**

[CHILDHOOD CONDITIONS CATEGORY
The following covered childhood conditions apply only to children who meet the definition of Dependent Children and are insured under this Certificate:

[**Cerebral Palsy** means a confirmed Diagnosis of nonprogressive, neurological defect affecting muscle control. Diagnosis for Cerebral Palsy must be made by a Specialist Physician.]

[**Congenital Heart Disease** means a confirmed Diagnosis of at least one of the following covered heart conditions:

- coarctation of the aorta;
- Ebstein's anomaly;
- Eisenmenger syndrome;
- Tetralogy of Fallot;
- transposition of the great vessels; or
- any other congenital cardiac condition that requires life-saving surgery to survive.

It also means any one of the following specific conditions for which open heart surgery is performed to correct:

- aortic stenosis;
- atrial septal defect;
- discrete subvalvular aortic stenosis;
- pulmonary stenosis; or
- ventricular septal defect.

Exclusions:
Congenital Heart Disease does not include any of the following procedures:

- percutaneous atrial septal defect closure; or
- trans-catheter procedures which include balloon valvuloplasty.

The Diagnosis of Congenital Heart Disease must be made and the surgery must be recommended and performed by a Specialist Physician and supported by cardiac imaging acceptable to us.]

[**Cystic Fibrosis,** also known as mucoviscidosis, means the confirmed Diagnosis of a recessive genetic disease affecting most critically the lungs and also the pancreas, liver, and intestine. It is characterized by abnormal transport of chloride and sodium across the epithelium leading to thick viscous secretions. The Diagnosis of cystic fibrosis must be made by a Specialist Physician.]

[**Type 1 Diabetes Mellitus** means a confirmed Diagnosis where the Insured has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months. The Diagnosis of type 1 diabetes mellitus must be made by a Specialist Physician.]

[**Muscular Dystrophy** means a confirmed Diagnosis of one of a group of muscle diseases characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue. The confirmed Diagnosis of Muscular Dystrophy must be made by a Specialist Physician.]

[*Childhood Conditions Benefit Waiting Period:*
No benefit will be payable for any Childhood Condition and the Insured's insurance for such Childhood Condition will terminate if, within [30 days] following the effective date of the Dependent Child's insurance, the Dependent Child has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of such Childhood Condition (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of such Childhood Condition (covered or excluded under this insurance).

Although the Insured's insurance for such Childhood Condition terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for a Childhood Condition or any Critical Illness caused by a Childhood Condition or its Treatment.

The Childhood Conditions Benefit Waiting Period does not apply when newborn or newly adopted children are added to your Dependent Children Insurance.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Childhood Conditions Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Childhood Conditions Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Childhood Conditions Benefit Waiting Period.**]]**

[10.] LIMITATIONS AND EXCLUSIONS

What exclusions apply to the benefits payable?
In addition to the exclusions stated in the Covered Conditions section of this Certificate, we will not pay any benefit that is caused by, contributed to in any way, or resulting from any of the following:

- any Critical Illness condition Diagnosed outside the United States or Canada without confirmation of the Diagnosis by the type of Specialist Physician specified for each of the Covered Conditions in Section [9] who practices in the United States or Canada[; or
- any Critical Illness procedure performed outside the United States or Canada].

We will not pay a benefit for any Critical Illness that is due to or results from:

- intentionally self-inflicted injuries;
- elective plastic or cosmetic surgery;
- active military duty;
- participation in war, declared or undeclared, or any act of war;
- [active participation in a riot, rebellion or insurrection;]
- [committing or attempting to commit an assault, felony or other criminal act;]
- [engagement in dangerous conduct or hazardous activity where there is a likelihood of death or serious injury;]
- [being legally intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed; or]
- [improper or illegal use of inhalants or huffing].

What limitations apply to the benefits payable?
In addition to the limitations stated in the Covered Conditions section of this Certificate, we will not pay any benefit for any Critical Illness that is Diagnosed in the first [12 months] following the effective date of any Insured's insurance and results from a Pre-Existing Condition.

Pre-Existing Condition means during the [6 months] prior to any Insured's effective date of insurance, any condition for which any Insured:

- sought medical treatment, consultation, advice, care or services, including diagnostic measures for the condition, regardless of whether the condition was diagnosed or suspected at that time;
- took prescribed drugs or medicines for the condition[; or
- had symptoms for which an ordinarily prudent person would have consulted a health care provider for Diagnosis, care or Treatment].

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Pre-Existing Condition limitation toward the satisfaction of the period of time required by this Certificate's Pre-Existing Condition limitation.

What are the maximum benefits payable under this Certificate?
[We will only pay one benefit for each Covered Condition shown in the Benefit Highlights.] We will not pay more than an aggregate of [100%] of the benefits payable for all Covered Conditions in the same Category as shown in the Benefit Highlights. [We will not pay more than an aggregate of [200%] of the benefits payable for all the Covered Conditions in all Categories shown in the Benefit Highlights.]

[11.] CLAIMS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us written Notice and Proof of claim within the time limits specified.

NOTICE OF CLAIM

When does written Notice of Claim have to be submitted?
Written notice of claim must be given to us no later than [60 days] after the date of Diagnosis or within [90 days] of the Treatment of the Critical Illness.

If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

When we receive written notice of claim, we will send the forms for Proof of claim. If the forms are not received within [15 days] after written notice of claim is sent, Proof of claim may be sent to us without waiting to receive the Proof of claim forms.

PROOF OF CLAIM

When does written Proof of claim have to be submitted?
Proof of claim must be given to us no later than [120 days] after the date of Diagnosis or Treatment of the Critical Illness.

If Proof cannot be given within these time limits, Proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time Proof is otherwise required unless the individual is legally incompetent.

What is considered Proof of claim?
Proof of claim must consist of at least the following information:

- a description of the Critical Illness;
- the date the Diagnosis and/or Treatment occurred; and
- the cause of the Critical Illness.

Proof of claim may include, but is not limited to, police accident reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials, as required.

We may require as part of the Proof, authorizations to obtain medical and non-medical information. Proof must be satisfactory to us.

PAYMENT OF BENEFITS

When are benefits payable?
Benefits are payable upon our receipt of satisfactory Proof of claim that establishes benefit eligibility according to the provisions of this Certificate.

When will a decision on your claim be made?
We will send you a written notice of our decision on your claim within a reasonable time after we receive the claim but not later than [45 days] after receipt of the claim. If we cannot make a decision within [45 days] after receiving your claim, we will request a [30-day] extension as permitted by U.S. Department of

Labor regulations. If we cannot render a decision within the extension period, we will request an additional [30-day] extension. Any request for extension will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have [45 days] to provide the specified information.

What if your claim is denied?
If we deny all or any part of your claim, you will receive a written notice of denial setting forth:

- the specific reason(s) for the denial;
- the specific Certificate provision(s) on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- [your right to bring a civil action under ERISA, §502(a) following an adverse determination on review.]
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

Can you request a review of a claim denial?
If all or part of your claim is denied, you may request in writing a review of the denial within [180 days] after receiving notice of denial.

You may submit written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

We will review the claim on receipt of the written request for review, and will notify you of our decision within a reasonable time but not later than [45 days] after the request has been received. If an extension of time is required to process the claim, we will notify you in writing of the special circumstances requiring the extension and the date by which we expect to make a determination on review. The extension cannot exceed a period of [45 days] from the end of the initial period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have at least [45 days] to provide the specified information.

What if your claim is denied on review?
If we deny all or any part of your claim on review, you will receive a written notice of denial setting forth:

- the specific reasons for the denial;
- the specific Certificate provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- [your right to bring a civil action under ERISA, §502(a);]

- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request;
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency."; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the appeal, regardless of whether the advice was relied upon to deny the appeal.

To whom are benefits payable?
We will pay you all benefits, if your Proof of claim is satisfactory to us, except in the following situations:

1. You are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons;
2. Due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described in item 1; or
3. You die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay to such person or persons.

If we do not pay you and claim is not made by the appropriate person designated above, we may, at our option, make payments under either or both Methods A or B below. Any decision to pay any benefits, prior to the appointment of the appropriate person designated in items [1, 2, or 3 above], is solely at our discretion, and we may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

Method A: We may pay up to the sum of [$5,000] to any individual or entity we determine has incurred or paid expenses as a result of funeral services provided to or on your behalf. If we pay such a benefit, we will not have to pay that benefit amount again and the total benefit due under this Certificate shall be reduced by the amount paid under this provision.

Method B: We may pay the whole or any part of such benefit:
- to your lawful spouse, up to a cumulative amount of [$5,000]; or
- if you have no lawful spouse, up to a cumulative amount of [$5,000] to any one or more of the following relatives in the following order of priority:

    1. your child or children; or
    2. your mother or father.

[12.] GENERAL PROVISIONS

ALTERATION

Who can alter this Certificate?
The only persons with the authority to alter or modify this Certificate or to waive any of its provisions are our president, actuary, secretary or one of our vice presidents and any such changes must be in writing.

[ASSIGNMENT

Can benefits be assigned?
You cannot assign any interest in this Certificate unless we agree in writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by us will discharge our liabilities under this Certificate, to the extent of such payments.]

CLERICAL ERROR

What happens when there is a clerical error in the administration of this Certificate**?**
Clerical errors in connection with this Certificate or delays in keeping records for this Certificate whether by us or the Policyholder:

- will not terminate insurance that would otherwise have been effective.
- will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error, subject to the "Limit of Premium Refunds" section.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of this Certificate conflicts with any applicable law, the provisions of this Certificate will be automatically amended to meet the minimum requirements of the law and to reflect updated statutory references.

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under this Certificate?
Payment made under the terms of this Certificate will, to the extent of such payment, release us from all further obligations under this Certificate. We will not be obligated to see to the application of such payment.

EXAMINATION

What are our examination rights?
We, at our own expense, have the right to have any person whose Critical Illness is the basis of a claim:

- examined by a Physician, Specialist Physician, other health professional or vocational expert of our choice; and/or

- interviewed by an authorized representative.

This right may be used as often as reasonably required.

INCONTESTABILITY

What is Incontestability?
Except for non-payment of premium, fraud, any claims incurred within two years of the effective date of an Insured's initial or reinstated insurance or as otherwise stated in this provision, we cannot contest the validity of such insurance regarding any Insured after it has been in force during the lifetime of such Insured for a period of two years from the Certificate Effective Date.

Additionally, for any insurance provided under the Policy that results from a statement of insurability submitted under the Qualifying Group Insurance Policy, except for any claims incurred before that insurance has been in force under the Qualifying Group Insurance Policy and this Policy for an aggregate period of two years during the insured's lifetime, measured from the effective date of the insurance for which the statement was provided, we cannot contest the validity of such insurance based on that statement.

This provision shall not preclude the assertion at any time of a defense to a claim based upon the Insured's eligibility for insurance.

INSURER'S AUTHORITY

What is our authority?
We have discretionary authority to make all final determinations regarding claims for benefits. This discretionary authority includes, but is not limited to, the determination of eligibility for benefits, based upon enrollment information provided by the policyholder of the Qualifying Group Insurance Policy, and the amount of any benefits due, and to construe the terms of the Policy.

Any decision made by us in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing our determinations shall uphold such determination unless the claimant proves that our determinations are arbitrary and capricious.

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of this Certificate?
If relevant facts about the Participant relating to this insurance are not accurate:

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the true facts will decide whether, and in what amount, and for what duration insurance is valid under this Certificate.

NON-PARTICIPATING

Does this Certificate participate in dividends?
This Certificate is non-participating and will not share in any profits or surplus earnings of Sun Life Assurance Company of Canada, and, therefore, no dividends are payable.

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?
No legal action may start:

- until [60 days] after Proof has been given; nor
- more than [3 years] after the time Proof of claim is required.

LIMIT OF PREMIUM REFUNDS

Is there a limit on premium refunds?
Whether premiums were paid in error or otherwise, we will refund only that part of the excess premium that was paid during the [12-month] period that preceded the date we learned of such overpayment.

NOTICE

How are required notices provided?
Any obligation we may have to give written notice will be satisfied by sending such notice to the last known address of the person or institution entitled to such notice.

PREMIUM PAYMENTS AS EVIDENCE OF INSURANCE

Does the payment of premiums guarantee coverage under the Policy?
The receipt of premiums by us is not a guarantee of insurance. Eligibility for benefits will be determined at the time of claim submission and all Policy requirements must be satisfied.

REIMBURSEMENT

What if a benefit is underpaid or overpaid?
Reimbursement will be made to us for any overpayments that we may make due to any reason. You must repay us within 60 days unless we agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If we have underpaid a benefit for any reason, we will make a lump sum payment for that amount.

Interest does not accrue on any underpaid or overpaid benefit unless required under the applicable law.

STATEMENTS

Are statements warranties?
In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by you in enrolling for insurance under the Policy will be used to reduce or deny a claim unless a copy of your written application for insurance is or has been given to you, your beneficiary, if any, or to your estate representative.

TIME PERIODS

What time periods apply to this Certificate?
For the purpose of effective dates and termination dates under this Certificate, all days begin at 12:00 midnight and end at 11:59:59 PM at the Participant's location.

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Critical Illness Insurance Certificate
[Critical Illness and Cancer]

Non-Participating

Sun Life Assurance Company of Canada
Statement of Variability

Form #: GMPAP-2548

Revision Date: September 27, 2012

Variability denoted by bracketing

Field	Scope of Variation
Header	Text will show to the extent Disability and/or Critical Illness coverage is available for Portability. Section numbers will change to reflect the actual coverage options available for Portability.
1. General information	
Social Security No.	Variability only to the extent that the company may ask for the last four digits of the Social Security number or the whole Social Security number. Information is to be used to identify those to whom benefits are payable.
2. Coverage amount information	
Disability insurance coverage amount	Text will show to the extent Disability coverage is available for Portability. Section numbers will change to reflect the actual coverage options available for Portability. Section numbers of the Portability Notice could change to reflect changes in administrative requirements Options under this category will appear to the extent they are is available for Portability and include: • Short Term Disability • Long Term Disability • Customized Disability
Critical Illness insurance coverage amount	Text will show to the extent Critical Illness coverage is available for Portability. Section numbers will change to reflect the actual coverage options available for Portability. Section numbers of the Portability Notice could change to reflect changes in administrative requirements Options under this category will appear to the extent they are is available for Portability and include: • Employee Critical Illness Only insurance • Employee Critical Illness and Cancer insurance • Employee Critical Illness, Cancer Only insurance • Spouse Critical Illness Only insurance • Spouse Critical Illness and Cancer insurance • Spouse Critical Illness, Cancer Only insurance • Child Critical Illness Only insurance • Child Critical Illness and Cancer insurance • Child Critical Illness, Cancer Only insurance Social Security number variability only to the extent that the company may ask for the last four digits of the Social Security number or the whole Social Security number. Information is to be used to identify those to whom benefits are payable.

Field	Scope of Variation
4. Fraud Warning	
Fraud warnings	The fraud warning sections are bracketed only so that we may change fraud language to comply with future changes to state law or regulation.
5. Acknowledgment and signature	
	31 days may vary between 30 days - 180 days. Signature of Employee may not be required in the case of a porting Spouse. Spouse signature may be required if applying for Critical Illness coverage.
Contact us	
Contact Information	Office address, telephone and internet address reflects current information but may be changed to reflect new address, telephone or internet address.

Sun Life Assurance Company of Canada
Statement of Variability

Form #: 12-SDPort-C-01

Revision Date: September 27, 2012

Variability denoted by bracketing

Field	Scope of Variation
Cover Page	
Executive Office	Executive Office address, telephone and internet address reflects current information but may be changed to reflect new address, telephone or internet address.
Policy Number	Hypothetical - John Doe specimen information.
Policy Effective Date	Hypothetical - John Doe specimen information.
Policyholder	Hypothetical - John Doe specimen information.
Certificate Number	Hypothetical - John Doe specimen information.
Certificate Effective Date	Hypothetical - John Doe specimen information.
Issue State	Hypothetical - John Doe specimen information.
Company Officers	In the event the signature or title of an officer signing the form changes, any new signature or title utilized will be that of an officer of the company.
Critical Illness and Cancer	Text will change to reflect the actual coverage election by the Policyholder and/or Employee and may include Critical Illness, Critical Illness and Cancer, or Cancer Only.
Corporate logo	Will vary to reflect future change.
Notice to Certificateholder language	Added this language as required by Arkansas Statute: 23-79-138. Variability within this page is to accommodate future changes.
TABLE OF CONTENTS	
TABLE OF CONTENTS	Text and Section numbers will change to reflect the actual coverage election by the Policyholder and/or Employee and may include: • Spouse Insurance • Dependent Children Insurance
1. BENEFIT HIGHLIGHTS	
Participant	Hypothetical - John Doe specimen information.
Premium Due Date	Text will appear to the extent premiums are required for coverage. Frequency will vary and may include: • The first day of each month • The first day of each quarter • The first day of each year

Field	Scope of Variation
Participant Insurance Amount	The amount of insurance and Minimum may vary between $5,000 - $100,000. If a range of insurance amounts are available, then Change Increment Amount and Minimum will print. Change Increment Amount varies between $1,000 - $25,000. The Insured is John Doe specimen information.
Spouse Insurance Amount	The amount of insurance and Minimum may vary between $5,000 - $100,000. If a range of insurance amounts are available, then Change Increment Amount and Minimum will print. Change Increment Amount varies between $1,000 - $25,000. The Insured is John Doe specimen information.
Dependent Children Insurance	The amount of insurance and Minimum may vary between $5,000 - $100,000. If a range of insurance amounts are available, then Change Increment Amount and Minimum will print. Change Increment Amount varies between $1,000 - $25,000. The Insured is John Doe specimen information.
Circulatory Conditions Category	Text will show with Participant election of the type of insurance and the Covered Conditions that may apply from the list shown below for the plan issued. The Benefit Percentage ranges from 10% to 100% for each benefit. • Heart Attack • Stroke • Heart Transplant • Coronary Artery Bypass Surgery • Aortic Surgery • Coronary Artery Angioplasty The following Covered Condition will apply in place of Heart Transplant when the plan is issued in connection with an HDHP/HSA program: • End-stage Heart Failure
Cancer Conditions Category	Text will show with Participant election of the type of insurance and the Covered Conditions that may apply from the list shown below for the plan issued. The Benefit Percentage ranges from 10% to 100% for each benefit. • Cancer • Non-Life Threatening Cancer
Other Conditions Category	Text will show with Participant election of the type of insurance and the Covered Conditions that may apply from the list shown below for the plan issued. The Benefit Percentage ranges from 10% to 100% for each benefit. • Benign Brain Tumor • Coma • Major Organ Failure • Paralysis • Severe Burns
Covered Childhood Conditions Category	Text will show with Participant election of Dependent Children Insurance and the Covered Conditions that may apply from the list shown below for the plan issued. The Benefit Percentage ranges from 10% to 100% for each benefit. • Cystic Fibrosis • Congenital Heart Disease • Cerebral Palsy • Type 1 Diabetes Mellitus • Muscular Dystrophy The following Covered Conditions will apply in place of Congenital Heart Disease when the plan is issued in connection with an HDHP/HSA program: • Complex Congenital Heart Disease
Maximum Benefits Payable for each Insured under this Certificate	The percentage of the benefit for Covered Conditions in the same category may change between 100% - 200%. If there is a benefit cap beyond Covered Conditions in the same category, the percentage may change between 100% - 400%. Changes will be based on a future determination by the Company after an actuarial pricing evaluation. Any pricing change would apply to new issues on a going forward basis only.
2. DEFINITIONS	

Field	Scope of Variation
Clinical Diagnosis	Text will show if Cancer coverage is elected.
Critical Illness	The bracketed text will not show when the plan is issued in connection with an HDHP/HSA program.
Dependent Child	Text will show if Dependent Children Insurance is elected and will change based on requirements specified by the Policyholder, the requirements of the Affordable Care Act, benefits mandated by state laws or regulations, or additional federal legislation. The child may or may not be required to be unmarried. The child's age may vary between 23 – 30, may be required to be a student and be reliant on the Participant for 25% - 75% of the child's support. An exception may exist for a child enrolled in an employer-sponsored medical plan other than the parent's. A Dependent Child can include: • an Participant's unmarried step-child; • a child for whom the Participant has legal guardianship; • a foster child placed with the Participant by a licensed agency; • an Participant's adopted child, including any child placed with the Participant for adoption; • an E Participant's grandchild who may or may not depend on the Participant for support; • a child for whom coverage is required pursuant to a Qualified Medical Child Support Order or other court administrative order; or • a child of a Spouse. If Policyholder plan requirements include children older than a specified age, the plan may require the child be such as the following: • incapable of self-sustaining employment because of a mental retardation, developmental disability or physical handicap; and • dependent on the Participant for between 25% - 75% % or more of his/her support. Dependent Child coverage may be limited to one parent if both parents are eligible for the same Participant coverage. Exceptions may also exist similar to the following: • any person who is insured as a Participant; or • any person residing outside the United States. This exclusion may or may not apply to a Dependent Child who resides with a Participant who is on a temporary work assignment outside the United States. The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable.
Divorce	Text will show if Spouse Insurance is elected.
Marriage	Text will show if Spouse Insurance is elected. The definition of Marriage will change to the extent necessary to meet Policyholder plan designs and comply with state laws and regulations regarding legally recognized same-sex unions and domestic partnerships.
Spouse	Text will show if Spouse Insurance or Portability is elected under the Policyholder's plan. The definition of Spouse will change to the extent necessary to meet Policyholder plan designs and comply with state laws and regulations regarding legally recognized same-sex unions and domestic partnerships. Exceptions may also exist similar to the following: • any person who is insured as an Employee; or • any person residing outside the United States. This exclusion does not apply to a Spouse who resides with an Employee who is on a temporary work assignment outside the United States. The Policyholder's plan may exclude any person residing outside of the U.S., Mexico, or Canada. Another country could be included if applicable.

Field	Scope of Variation
3. PORTABILITY	
When are you eligible for portability insurance?	60 months may vary between 12 months - 120 months. The Policyholder plan may require the Insured to be under qualifying group policy coverage for a certain amount of time for it to be portable. 36 consecutive months may vary between 12 consecutive months - 48 consecutive months. Any or all of the following may appear: • leave of absence • labor strike • retirement • sickness • injury The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable. The Policyholder's plan may exclude portability if other coverage with the company was already ported. The Policyholder's plan may exclude portability if the insured is over a specified age. Age 70 may vary between 35 - 99.
What is the amount of portable insurance?	100% may vary between 25% - 100%.
When is portability available to the Spouse and when is the Spouse eligible?	Text will appear to reflect the actual coverage election by the Policyholder and/or Participant. 60 months may vary between 12 months - 120 months. Any or all of the following may appear: • die • Divorce your Spouse • are terminated The Policyholder plan may require the Insured to be under qualifying group policy coverage for a certain amount of time for it to be portable. 36 consecutive months may vary between 12 consecutive months - 48 consecutive months. The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable. Age 70 may vary between 35 - 99. Any or all of the following may appear: • death • Divorce • termination

Field	Scope of Variation
What is the amount of the Spouse's portable insurance?	100% may vary between 25% - 100%. Any or all of the following may appear: • death • Divorce • termination Text regarding Dependent Children Insurance based on Policyholder election of same.
When does the Spouse's portable insurance start?	Any or all of the following may appear: • death • Divorce • termination
4. EFFECTIVE DATES AND TERMINATION OF PARTICIPANT INSURANCE	
How can you make changes in Participant Insurance?	Decreases may be subject to the limits shown in Benefit Highlights section (e.g. one level decrease or a specific dollar amount decrease).
When does Participant Insurance end?	60 months may vary between 12 months - 120 months. If the duration will be to Age 70 or is unlimited, this sentence will be removed. Participant age may or may not be a determining factor of when Participant Insurance Ends. Age 70 may vary between 35 - 99. If the duration will be unlimited, this sentence will be removed. The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable. Participant Insurance may terminate if the Participant is again under the qualifying group insurance policy.
5. EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE	
5. EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE	Text will appear if elected by the Policyholder and/or Participant.
How can you make changes in Spouse Insurance?	Decreases may be subject to the limits shown in Benefit Highlights section (e.g. one level decrease or a specific dollar amount decrease).
When does Spouse Insurance end?	60 months may vary between 12 months - 120 months. If the duration will be to Age 70 or is unlimited, this sentence will be removed. Spouse age may or may not be a determining factor of when Spouse Insurance Ends. Age 70 may vary between 35 - 99. If the duration will be unlimited, this sentence will be removed. The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable. Spouse Insurance may terminate if the Participant is again under the qualifying group insurance policy.
6. EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE	
6. EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE	Text will appear and Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.

Field	Scope of Variation
How can you make changes in Dependent Children Insurance?	Decreases may be subject to the limits shown in Benefit Highlights section (e.g. one level decrease or a specific dollar amount decrease).
When does Dependent Children Insurance end?	60 months may vary between 12 months - 120 months. If the duration will be to Age 70 or is unlimited, this sentence will be removed. The Policyholder's plan may exclude any person residing outside of the U.S. or Canada. Another country could be included if applicable. Dependent Children Insurance may terminate if the Participant is again under the qualifying group insurance policy.
7. PREMIUMS	
7.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
When are your premiums due and how are they determined?	The Executive Office may be changed to our Service Office or a specific address we designate for the collection of premiums. If Canadian dollars are accepted as premium, the following language may appear: • and Canadian dollars; • and Canadian dollars at the accepted daily rate of exchange.
Can premium rates that apply to your insurance change?	We may reserve the right to recalculate the premium rate after an initial time period. 12 months may vary between 12 months - 60 months.
What is the grace period?	31-day may vary between 31-day - 365-day.
8. BENEFIT PROVISIONS	
8.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
What benefits are payable?	The bracketed text will not show when the plan is issued in connection with an HDHP/HSA program.
9. COVERED CONDITIONS	
9.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
What Critical Illness conditions are covered?	The bracketed text will not show when the plan is issued in connection with an HDHP/HSA program.

Field	Scope of Variation
Circulatory Conditions Category	Text will show with Policyholder and/or Participant election of the type of insurance and the Covered Conditions that apply from the list shown below for the plan issued. • Heart Attack • Stroke • Heart Transplant • Coronary Artery Bypass Surgery • Aortic Surgery • Coronary Artery Angioplasty 30 days could vary between 15 - 180 days. The following will show in place of Heart Transplant when the plan is issued in connection with an HDHP/HSA program: **[End-stage Heart Failure** means a confirmed diagnosis of severe and irreversible failure of the heart which is not remediable by medical or device therapy or by surgical therapy other than heart transplant. To qualify under End-stage Heart Failure, the Insured must be listed with the United Network of Organ Sharing (UNOS) on a Heart Transplant waiting list. Severe and irreversible failure of the heart shall be conclusively proven if an Insured has undergone a Heart Transplant as the recipient while insured under the Policy. The diagnosis of End-stage Heart Failure must be made by a Specialist Physician.]
Cancer Conditions Category	Text will show with Policyholder and/or Participant election of the type of insurance and the Covered Conditions that apply from the list shown below for the plan issued. • Cancer • Non Life-Threatening Cancer • Cancer Benefit Waiting Period • Non-Life Threatening Cancer Benefit Waiting Period Text regarding recurrence will show based on a future product design change. 30 days could vary between 15 - 180 days. 6 months could vary between 30 days - 36 months.
Other Conditions Category	Text will show with Policyholder and/or Participant election of the type of insurance and the Covered Conditions that apply from the list shown below for the plan issued. • Benign Brain Tumor • Coma • Benign Brain Tumor Benefit Waiting Period • Major Organ Failure • Paralysis • Severe Burns Text regarding recurrence will show based on a future product design change. 30 days and 90 days could vary between 15 - 180 days. 6 months could vary between 30 days - 36 months.
Major Organ Failure	The first bulleted item in brackets under the first paragraph is replaced with the following when the plan is issued in connection with an HDHP/HSA program: • for kidney failure only, in the absence of a listing on UNOS, ongoing dialysis (either hemo or peritoneal) on a permanent basis, shall be conclusive proof of irreversible end-stage kidney failure; The first bulleted item in brackets under the third paragraph is replaced with the following when the plan is issued in connection with an HDHP/HSA program: • for kidney failure only, in the absence of a listing on UNOS, ongoing dialysis (either hemo or peritoneal) on a permanent basis, shall be conclusive proof of irreversible end-stage kidney failure,

Field	Scope of Variation
Childhood Conditions Category	Text will show with Policyholder and/or Participant election of Dependent Children Insurance and a Covered Condition as shown below. • Cystic Fibrosis • Cerebral Palsy • Muscular Dystrophy • Congenital Heart Disease • Type 1 Diabetes Mellitus • Childhood Conditions Benefit Waiting Period 30 days could vary between 15 - 180 days. 6 months could vary between 30 days - 36 months.
Congenital Heart Disease	The following will show in place of Congenital Heart Disease when the plan is issued in connection with an HDHP/HSA program: **Complex Congenital Heart Disease** means a confirmed Diagnosis of at least one of the following covered heart conditions: • coarctation of the aorta; • Ebstein's anomaly; • Eisenmenger syndrome; • Tetralogy of Fallot; • transposition of the great vessels; or • any other congenital cardiac condition that requires life-saving, open heart surgery to survive. It also means any one of the following specific conditions that require life-saving, open heart surgery to survive: • aortic stenosis; • atrial septal defect; • discrete subvalvular aortic stenosis; • pulmonary stenosis; or • ventricular septal defect. The Diagnosis of Complex Congenital Heart Disease must be made and the surgery must be recommended by a Specialist Physician and supported by cardiac imaging acceptable to us.
10. LIMITATIONS AND EXCLUSIONS	
10.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
What exclusions apply to the benefits payable?	The second bulleted item bracketed under the first paragraph will not show when the plan is issued in connection with an HDHP/HSA program. Any combination of the following exclusions may show if applicable under the Policyholder's plan: • active participation in a riot, rebellion or insurrection; • committing or attempting to commit an assault, felony or other criminal act; • your engagement in dangerous conduct or hazardous activity where there is a likelihood of death or serious injury; • being legally intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed; or • improper or illegal use of inhalants or huffing
What limitations apply to the benefits payable?	12 months will vary between 12 and 24 months.

Field	Scope of Variation
Pre-Existing Condition	The look-back from the effective date of coverage will vary between 3, 6, or 12 months. Text will be included regarding increases in insurance if same is allowed under the Policyholder's plan. Text regarding symptoms for which an ordinarily prudent person would have consulted a health care provider may show if required under the Policyholder plan.
What are the maximum benefits payable under this Certificate?	Text regarding one benefit payment will not show if a recurrence benefit rider is elected. The percentage of the benefits payable for all Covered Conditions in the same category may change between 100% - 200%. The percentage of the benefits payable for all the Covered Conditions in all Categories may change between 100% - 400%.
11. CLAIMS	
11.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
When does written Notice of Claim have to be submitted?	60, 90, and 15 days may vary from 30 days - 24 months based on Policyholder requirements and as mandated by state laws or regulations.
When does written Proof of claim have to be submitted?	120 days may vary from 30 days - 24 months based on Policyholder requirements and as mandated by state laws or regulations.
When will a decision on your claim be made?	45 days and 30 day may vary from 10 days – 45 days based on ERISA requirements and as mandated by Federal laws or regulations.
What if your claim is denied?	Text will show if the plan is subject to ERISA and may vary to comply with federal requirements.
Can you request a review of a claim denial?	180 days may vary from 90 days - 365 days. 45 days may vary from 10 days – 45 days based on Policyholder requirements and as mandated by state laws or regulations.
What if your claim is denied on review?	Text will show if the plan is subject to ERISA.
To whom are benefits payable?	$5,000 may vary between $1,000 - $10,000 based on ERISA requirements and as mandated by Federal laws or regulations.
12. GENERAL PROVISIONS	
12.	Section numbers will change to reflect the actual coverage election by the Policyholder and/or Participant.
ASSIGNMENT	Text will show if the benefits are assignable.
LEGAL PROCEEDINGS	60 days may vary between 60 days - 90 days. 3 years may vary between 2 years – 6 years.
LIMIT OF PREMIUM REFUNDS	12 months may vary between 6 months - 36 months.
BACK PAGE	

Field	Scope of Variation
Critical Illness and Cancer	Text will change to reflect the actual coverage election by the Policyholder and/or Employee and may include Critical Illness, Critical Illness and Cancer, or Cancer Only.
Corporate logo	Will vary to reflect future change.

Sun Life Assurance Company of Canada

Portability Application – [Disability] [and] [Critical Illness]

Please complete the sections indicated below, read the fraud warnings and acknowledgement, and sign and date the form. Mail the completed form, a copy of your Portability Notice, and a check for the first premium to Sun Life Assurance Company of Canada. Questions about portability? Please call 1-800-247-6875.

I am applying for Portable:

[☐ Disability insurance (complete sections 1, [2.1], 3 and 5)]

[☐ Critical Illness insurance (complete sections 1, [2.2], 3 and 5)]

1 General information

Your name (first, middle initial, last)			Date of birth (m/d/y)
Residence address (street number & name, apartment or suite)	City	State	Zip
Social Security number [ ]	Home phone number	Alternate phone number	

Information about the qualifying group policy(ies)

Name of group policyholder (i.e., your employer or plan administrator)	Policy number(s)

2 Coverage amount information

[[2.1] Disability insurance coverage amount

See section [3] of the Portability Notice for the amount of insurance you are eligible to apply for. You may apply for coverage only if your employer's plan includes this option. You may elect to keep the current amount(s) of disability coverage you had with your prior employer or elect a lower amount. Check one box for each coverage you are requesting to port and write in the amount elected.

[Short-Term Disability ☐ Elect to keep current amount ☐ Elect a lower amount	Amount elected $]
[Long-Term Disability ☐ Elect to keep current amount ☐ Elect a lower amount	Amount elected $]
[Customized Disability insurance ☐ Elect to keep current amount ☐ Elect a lower amount	Amount elected $]

]

[2 Coverage amount information, continued]

[[2.2] Critical Illness insurance coverage amount]

See section [3] of the Portability Notice for the amount of insurance you are eligible to apply for. You may apply for Critical Illness coverage only if your employer's plan includes this option. You may elect to keep the current amount(s) of Critical Illness coverage you had with your prior employer, or elect a lower amount. Check one box for each coverage you are requesting to port and write in the amount elected.

You may only port spouse/child benefits if you are electing to port your employee benefits and if your spouse/child were insured under the group policy at the time of your termination. Under limited conditions, spouses may be eligible to apply for portable spouse/child insurance. Contact us at the number shown above for details.

[Employee Critical Illness Only insurance ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Employee Critical Illness and Cancer insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Employee Critical Illness, Cancer Only insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]
[Spouse Critical Illness Only insurance ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Spouse Critical Illness and Cancer insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Spouse Critical Illness, Cancer Only insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]
[Child Critical Illness Only insurance ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Child Critical Illness and Cancer insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]	**[Child Critical Illness, Cancer Only insurance** ☐ Elect to keep current amount ☐ Elect a lower amount Amount elected $]

If you have elected spouse and/or child(ren) coverage above, be sure to write in the spouse/child(ren) name(s) and date(s) of birth.

Spouse name (first, middle initial, last)	Social Security number [ ]	Date of birth (m/d/y)
Child name (first, middle initial, last)	Social Security number [ ]	Date of birth (m/d/y)
Child name (first, middle initial, last)	Social Security number [ ]	Date of birth (m/d/y)

If you need additional space, check here ☐ and attach a separate sheet.]

3 Premium information

Premium payment

Amount enclosed $	How would you prefer to pay premiums? ☐ Annually ☐ Semi-annually ☐ Quarterly

4 Fraud warnings

[General fraud warning: Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[For AL the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.]

4 Fraud warnings, continued

[For AR, LA, MA, NM, RI, and WV, the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For CO the following warning applies: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.]

[For the District of Columbia the following notice applies: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For FL the following notice applies: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[For KS the following notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.]

[For KY the following notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.]

[For MD the following notice applies: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For ME, TN, VA, and WA the following notice applies: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

[For NJ the following notice applies: Any person who knowingly includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[For OH the following notice applies: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud**.]**

[For OK the following notice applies: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[For OR the following notice applies: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

[For PR the following notice applies: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.]

5 Acknowledgment and signature

To begin processing your request for portability coverage, Sun Life Assurance Company of Canada must receive this signed Application form, any other required documentation, and your first premium within [31] days of your termination date.

No insurance requested in this Application form will become effective until Sun Life Assurance Company of Canada accepts the Application, notifies you of its acceptance, and receives the first premium payment from you. If you submit the initial premium payment with the Application and Sun Life rejects the Application, Sun Life will refund the premium. If your Application is accepted, Sun Life will bill you for future premium payments. Rates will increase when you reach a new age band and may increase for reasons other than age. See the Portability Kit or ask your employer for rates and age bands.

You must read and sign to apply for coverage.
I/We understand and agree that: (1) My/Our eligibility for Portable Group Insurance will be based on the Portability conditions stated in the qualifying group policy(ies). (2) The answers and statements in this Application will be the basis for and become part of any insurance certificate issued as a result of this Application. (3) The certificate issued will replace the coverage provided by the group policy indicated in section 1 of this Application. (4) No insurance requested in this Application will be effective until Sun Life Assurance Company of Canada accepts this Application and receives my initial premium payment. (5) A claim may be denied in accordance with the Incontestability provision of the Portability Certificate if the statements in this Application are not complete and true. (6) All portable insurance will be subject to the terms and conditions of the Portable Group Insurance Certificate and the Group Policy under which it is issued.

Signature of employee X	Date

[(Employee's signature is not required above if spouse is porting due to divorce or death of the employee.)]

[Signature of spouse (if also applying for Critical Illness coverage)] X	Date

Contact us

By mail
Sun Life Assurance Company of Canada
[One Sun Life Executive Park], [SC 3015]
Wellesley Hills, MA 02481

[www.sunlife.com/us]

Customer Service [**800-247-6875]** M–F [8:30 a.m. – 6:00 p.m., ET]

SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
[One Sun Life Executive Park]
[Wellesley Hills, MA 02481]

[(800) 247-6875]
[www.sunlife.com/us]

Sun Life Assurance Company of Canada certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

Policy Number:	[00000001]
Policy Effective Date:	[September 1, 2012]
Policyholder:	[ABC Trust]
Certificate Number:	[12345]
Certificate Effective Date:	[September 1, 2012]
Issue State:	[Massachusetts]

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

This Certificate contains the terms of the Group Insurance Policy that affect your insurance. This Certificate is part of the Group Insurance Policy.

This Certificate is governed by the laws of the Issue State shown above.

Signed at Wellesley Hills, Massachusetts.

[Dean A. Connor]
[President and Chief Executive Officer]

[Dana J. Easthope]
[Vice-President, Associate General Counsel and Corporate Secretary]

Group Critical Illness Insurance Certificate
[Critical Illness and Cancer]

Non-Participating

Sun
[Life Financial[SM]]

NOTICE TO CERTIFICATEHOLDER

THIS NOTICE IS TO ADVISE YOU THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING YOUR SUNLIFE GROUP INSURANCE PLAN, YOU MAY CONTACT THE FOLLOWING:

SUN LIFE ASSURANCE COMPANY OF CANADA
[GROUP CUSTOMER SERVICE CENTER SC1219
U.S. HEADQUARTERS OFFICE
ONE SUN LIFE EXECUTIVE PARK
WELLESLEY HILLS, MA 02481
(800) 247-6875

ALSO AVAILABLE TO YOU IS THE CONSUMER SERVICES DIVISION OF THE ARKANSAS INSURANCE DEPARTMENT, [1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS 72201-1904, (501) 371-2640 or (800) 852-5494]

TABLE OF CONTENTS

1. BENEFIT HIGHLIGHTS

Participant: **John Doe**

[Premium Due Date: [The first day of each month] **]**

Insurance Amounts

[Participant Insurance Amount:	[$100,000] [Change Increment Amount: [$5,000]] Minimum: [$5,000]
Insured: [John Doe] **]**	
[Spouse Insurance Amount:	[$100,000] [Change Increment Amount: [$5,000]] Minimum: [$5,000]
Insured: [Jane Doe] **]**	
[Dependent Children Insurance:	[Change Increment Amount: [$5,000]] Minimum: [$5,000]
Insured: [Bill Doe]	[$100,000]
[Insured: [Bob Doe]]	[$100,000] **]**

[Circulatory Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Heart Attack	[100%]]
[Stroke	[100%]]
[Heart Transplant	[100%]]
[Coronary Artery Bypass Surgery	[25%]]
[Aortic Surgery	[25%]]
[Coronary Artery Angioplasty	[25%]] **]**

[Cancer Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Cancer	[100%]]
[Non-Life Threatening Cancer	[25%]] **]**

[Other Conditions Category - [Participant, Spouse and Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Benign Brain Tumor	[100%]]
[Coma	[100%]]
[Major Organ Failure	[100%]]
[Paralysis	[100%]]
[Severe Burns	[100%]] **]**

[Childhood Conditions Category - [Dependent Children Insurance]

Covered Condition	Benefit Percentages
[Cerebral Palsy	[100%]]
[Congenital Heart Disease	[100%]]
[Cystic Fibrosis	[100%]]
[Type 1 Diabetes Mellitus	[100%]]
[Muscular Dystrophy	[100%]] **]**

Maximum Benefits Payable for each Insured under this Certificate:

- We will only pay one benefit for each Covered Condition shown above;
- We will not pay more than an aggregate of [100%] of the benefit payable for Covered Conditions in the same Category**[**; and
- We will not pay more than an aggregate of [200%] of the benefit payable for all the Covered Conditions in all Categories shown above].

Note: All benefits available for Covered Conditions under this portability Certificate will be reduced by any benefits paid or payable under the Qualifying Group Insurance Policy. The Maximum Benefits available under this Certificate shall be reduced by any benefits paid or payable under the Qualifying Group Insurance Certificate.

2. DEFINITIONS

Benefit Percentage means the percentage that is applied to your Insurance Amount to determine the amount of Critical Illness benefits payable under the Policy.

[**Clinical Diagnosis** means a Diagnosis of Cancer based on observation and history, diagnostic and laboratory studies, and symptoms.]

Critical Illness means only the illnesses [or procedures] defined in the Covered Conditions section of this Certificate for which benefits are payable.

[Dependent Child means the Participant's:

- [[unmarried] child from live birth to under age [26] [who is enrolled as a full time student and depends on the Participant for [50%] or more of the child's support.]]

Dependent Child includes:

- **[**a Participant's [unmarried] step-child];
- [a child for whom the Participant has legal guardianship];
- [a foster child placed with the Participant by a licensed agency];
- a Participant's adopted child, including any child placed with the Participant for adoption;

[If [an] [unmarried] child is age [26] or older and is:

- **[**incapable of self-sustaining employment because of a mental retardation, developmental disability or physical handicap]; [and
- dependent on the Participant for **[**[50%] or more of his/her**]** support;**]**

that child will continue to be a Dependent under the Policy for as long as these conditions exist.**]**

[No person may be considered to be a Dependent Child of more than one Participant.]

Dependent Child does not include:

- **[**any person who is insured as a Participant; or]
- any person residing outside the [United States], [Canada], or [Mexico]. [This exclusion does not apply to a Dependent Child who resides with a Participant who is on a temporary work assignment outside the [United States].**]**

Diagnosis (Diagnosed) means a definitive identification of the Critical Illness made during the lifetime of the Insured by a Specialist Physician:

- supported by documentation of all appropriate and defined studies;
- based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
- meeting any diagnostic requirements stated in this Certificate for the particular Critical Illness being diagnosed.

[**Divorce** means the dissolution of any relationship identified in the Marriage definition and the term "divorce decree" means the court-issued document appropriate for the termination of such a relationship.]

Insurance Amount means the amount of insurance available under the Policy as shown in the Benefit Highlights and for which a person covered under the Policy is insured.

Insured means any person covered under the Policy as named in the Benefit Highlights.

[Marriage means any of the following relationships recognized under applicable state law: a same-sex or opposite-sex marriage; a civil union partnership under which the partners have the same legal rights and

responsibilities as a married couple; [and a same-sex or opposite-sex registered domestic partnership under which the partners have the same legal rights and responsibilities as a married couple.]**]**

Participant means a person who was insured under a Qualifying Group Insurance Policy and who applied for insurance under the Policy. The Participant eligible for insurance under this Certificate is shown in the Benefit Highlights.

Physician means an individual who is operating within the scope of his or her license and is either:

- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

The Physician cannot be you, a business associate or any family member. “Family member” means: (a) your spouse and (b) the following relatives of you or your spouse: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Policy means the group insurance policy under which this Certificate is issued.

Proof means any medical, financial, or other information that is required under by us and is satisfactory to us.

Qualifying Group Insurance Policy means the group insurance policy we issued which included the portability option to apply for insurance under the Policy.

Specialist Physician means a medical doctor who is licensed and practicing in the United States or Canada and who has completed an accredited specialty training program recognized by the American Board of Medical Specialties and has passed the examination leading to Board Certification in the field most applicable to the condition being evaluated or equivalent certification acceptable to us.

[Spouse means any individual who under applicable state law is either recognized as a spouse, partner to a civil union[, a partner to a registered domestic partnership] under which the partners have the same legal rights and responsibilities as a married couple, or are otherwise accorded the same rights as a spouse.

Spouse does not include any person residing outside the [United States], [Canada], or [Mexico]. [This exclusion does not apply to a Spouse who resides with a Participant who is on a temporary work assignment outside the [United States].] **]**

Treatment means a Physician's consultation, care or services; diagnostic measures; or the prescription, refill or taking of prescribed drugs or medicines.

We, Us, Our (we, us, our) means Sun Life Assurance Company of Canada.

You, Your (you, your) means the Participant who is eligible for insurance under this Certificate.

3. PORTABILITY

When are you eligible for portability insurance?
You are eligible under the Qualifying Group Insurance Policy to elect to continue your insurance for up to [60 months] if all of the following requirements are met:

- [you have been validly Insured under the Qualifying Group Insurance Policy for at least [36 consecutive months];]
- your insurance ends because you terminate employment for reasons other than [leave of absence, labor strike, retirement, sickness or injury];
- the Qualifying Group Insurance Policy is still in force;
- you reside in the United States [or Canada];
- [you have not exercised your portability right under a similar certificate issued by us;] and
- you are under age [70] at the time employment terminates.

Your new portability insurance is provided by this Certificate. Your new portability insurance may not be identical to your current insurance under the Qualifying Group Insurance Policy.

What is the amount of portable insurance?
You may apply for portable insurance in an amount up to [100%] of each Insured's remaining amount of insurance validly in force under the Qualifying Group Insurance Policy on the date your insurance terminates. In no instance will the insurance issued under this Certificate be greater than the remaining amount of insurance in force under the Qualifying Group Insurance Policy on the date such insurance terminates. Your new portability insurance policy will not provide any benefits beyond those described in this Certificate.

When does your portable insurance start?
After your insurance under the Qualifying Group Insurance Policy terminates, your portable insurance provided by this Certificate starts on the later of the following:

- the date we approve your application for portable insurance; and
- the date we receive your first premium payment for portable insurance.

[When is portability available to the Spouse and when is the Spouse eligible?
Portability is available for the Spouse under the Qualifying Group Insurance Policy for up to [60 months] if all of the following requirements are met:

- the employee under the Qualifying Group Insurance Policy [dies] [or Divorces their Spouse];
- **[**the employee under the Qualifying Group Insurance Policy had been Insured under the Policy for at least [36 consecutive months];**]**
- the Qualifying Group Insurance Policy is still in force;
- the Spouse resides in the United States [or Canada]; and
- the Spouse is under age [70] at the time of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy.

The Spouse's new portability insurance is provided by this Certificate. Their new portability insurance may not be identical to the insurance under the Qualifying Group Insurance Policy.

What is the amount of the Spouse's portable insurance?
The Spouse may apply for portable insurance in an amount up to [100%] of the remaining amount of [Spouse Insurance] [and Dependent Children Insurance] in force under the Qualifying Group Insurance Policy on the date of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy. In no instance will the [Spouse Insurance] [and Dependent Children Insurance] issued under this Certificate be greater than the remaining amount of [Spouse Insurance] [and Dependent Children Insurance] in force under the Qualifying Group Insurance Policy on the date of [death] [or Divorce] of the employee under the Qualifying Group Insurance Policy. The Spouse's new portability insurance policy will not provide any benefits beyond those described in this Certificate.

[The Spouse may not apply for portable insurance for a Dependent Child whose insurance has not terminated under the Qualifying Group Insurance Policy due to Divorce.]

When does the Spouse's portable insurance start?
After the [Death] [or Divorce] of the employee under the Qualifying Group Insurance Policy, the Spouse's portable insurance will start on the later of the following:

- the date we approve the Spouse's application for portable insurance; and
- the date we receive the Spouse's first premium payment for portable insurance.**]**

4. EFFECTIVE DATES AND TERMINATION OF PARTICIPANT INSURANCE

When does Participant Insurance start?
Participant Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

How can you make changes in Participant Insurance?
You may request a decrease in your Participant Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease your Participant Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Participant Insurance start?
Any reduction in your Participant Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Participant Insurance end?
Your Participant Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- [the date you attain age [70];]
- the last day for which any required premium has been paid for your Participant Insurance;
- the date you request in writing to end your Participant Insurance;
- [the date you reside outside the United States [or Canada;]
- [the date you become insured again under the Qualifying Group Insurance Policy;] or
- the date all benefits paid for you under the Policy reach the maximum amount payable as described herein.

[5. EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When does Spouse Insurance start?
Spouse Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

How can you make changes in Spouse Insurance?
You may request a decrease in your Spouse Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease the Spouse Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Spouse Insurance start?
Any reduction in your Spouse Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Spouse Insurance end?
Your Spouse Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- [the date your Spouse attains age [70];]
- the last day for which any required premium has been paid for your Spouse Insurance;
- the date you request in writing to end your Spouse Insurance;
- the date you reside outside the United States [or Canada];
- [the date you become insured again under the Qualifying Group Insurance Policy];
- the date all benefits paid for your Spouse under the Policy reach the maximum amount payable for your Spouse as described herein; and
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate.**]**

[[6.] EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

When does Dependent Children Insurance start?
Dependent Children Insurance starts on the Certificate Effective Date shown on the cover page of this Certificate.

[How can you make changes in Dependent Children Insurance?
You may request a decrease in your Dependent Children Insurance Amount to an amount not less than the minimum shown in the Benefit Highlights. [You may only decrease the Dependent Children Insurance Amount by the increment amount shown in the Benefit Highlights.]

When does a change in Dependent Children Insurance start?
Any reduction in your Dependent Children Insurance will start on the date we approve your request for such change in insurance. The premium for any reduced insurance will cause a pro-rata adjustment on the next Premium Due Date.

When does Dependent Children Insurance end?
Your Dependent Children Insurance will end on the earliest of the following to occur:

- [[60 months] from the Certificate Effective Date];
- the date the Policy terminates;
- the last day for which any required premium has been paid for your Dependent Children Insurance;
- the date you request in writing to end your Dependent Children Insurance;
- the date all benefits paid for you under the Policy reach the maximum amount payable as described herein;
- the date you reside outside the United States [or Canada];
- [the date you become insured again under the Qualifying Group Insurance Policy];
- for a specific Dependent Child, the date all benefits paid reach the maximum amount payable as described herein; and
- the date a Dependent Child no longer meets the definition of Dependent Child as described in this Certificate.**]**

[7.] PREMIUMS

When are your premiums due and how are they determined?
Your first premium is due on the Certificate Effective Date. Subsequent premiums are due on the Premium Due Date. Premiums are based upon the then current premium rates in effect for the benefits provided.

Premiums are payable to us at [our Executive Office] and will be paid in United States dollars [and Canadian dollars] [and Canadian dollars at the accepted daily rate of exchange], on the Premium Due Date.

Can premium rates that apply to your insurance change?
We determine initial and any subsequent premium rates. [We have the right to recalculate any premium rate after the initial premium rate has been in effect for [12 months].]

We will provide you written notice of any change in the premium rates at least [60] days prior to the effective date of the change.

What is the grace period?
The grace period is the [31-day] period of time following the Premium Due Date during which you may make an unpaid premium payment. If you do not pay the required premium before the end of the grace period, this Certificate will automatically terminate at the end of the grace period. Should any benefits become payable as a result of insurance provided during the grace period, we may deduct any premiums due from those benefits.

[8.] BENEFIT PROVISIONS

What benefits are payable?
We will pay you a lump-sum benefit for the insurance in force each time any eligible Insured, on or after the Certificate Effective Date:

- is Diagnosed with a Critical Illness condition[; or
- undergoes a Critical Illness procedure,]

as defined in the Covered Conditions section of this Certificate.

Any benefits payable are subject to the limitations, exclusions and other conditions stated in this Certificate.

How is the amount of the benefit determined?
We will multiply the Insured's Insurance Amount by the Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

[9.] COVERED CONDITIONS

What Critical Illness conditions are covered?
The Critical Illness conditions [and procedures] listed below are covered under the Policy.

[CIRCULATORY CONDITIONS CATEGORY

[**Heart Attack** means a confirmed Diagnosis of the death of heart muscle due to acute obstruction of a coronary artery that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction and includes at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a Heart Attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist Physician.

Exclusions:
Heart Attack does not include:
- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- silent myocardial infarction, including ECG or imaging changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.]

[Stroke (cerebrovascular accident) means a confirmed Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or cerebral embolism from an extra-cranial source, with:
- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination which persist for [30 days] following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The Diagnosis of Stroke must be made by a Specialist Physician.

Exclusions:
Stroke does not include any of the following:
- transient ischemic attacks;
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.**]**

[Heart Transplant means a confirmed Diagnosis of the irreversible failure of the heart and that transplant is medically necessary as soon as an appropriate donor is located. Heart Transplant under the Policy includes a procedure to replace the heart together with a lung, commonly referred to as a heart/lung transplant. To qualify under Heart Transplant, the Insured must be listed with the United Network of Organ Sharing (UNOS) on a Heart Transplant waiting list or have undergone a Heart Transplant as the recipient while insured under the Policy. The Diagnosis of the heart failure requiring Heart Transplant must be made by a Specialist Physician.]

[**Coronary Artery Bypass Surgery** means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-

catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a Specialist Physician.]

[**Aortic Surgery** means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist Physician.]

[**Coronary Artery Angioplasty** means the undergoing of balloon angioplasty, laser angioplasty, or atherectomy or the placement of a stent to correct narrowing or blockage of one or more coronary arteries. The Coronary Artery Angioplasty must be determined to be medically necessary by a Specialist Physician.]**]**

[CANCER CONDITIONS CATEGORY

Cancer means a confirmed Diagnosis of a tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist Physician.

A Clinical Diagnosis will be accepted only if:

- a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
- there is medical evidence to support the Diagnosis; and
- a Physician is treating you for Cancer.

In all other cases, Cancer must be Diagnosed with histopathological confirmation.

Exclusions:
Cancer does not include:

- carcinoma in situ;
- evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including, but not limited to, proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis; or
- any non-melanoma skin cancer that has not become metastasized.

No benefit will be payable under this provision for the Non-Life Threatening Cancers listed in the Non-Life Threatening Cancer provision below.

[No benefit will be payable for a recurrence or metastasis of an original Cancer which was Diagnosed prior to the effective date of insurance.]

[*Cancer Benefit Waiting Period:*
No benefit will be payable for Cancer and the Insured's insurance for Cancer and Non-Life Threatening Cancer will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the Insured's insurance; and
- the effective date of the Insured's insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of any cancer (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of any cancer (covered or excluded under this insurance).

Although the Insured's insurance for Cancer and Non-Life Threatening Cancer terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Cancer or Non-Life Threatening Cancer or any Critical Illness caused by any cancer or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Cancer Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Cancer Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Cancer Benefit Waiting Period. **]**

Non-Life Threatening Cancer is limited to the following:

- chronic lymphocytic leukemia that has not progressed beyond Rai stage 0;
- Stage 1A (T1a) malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion);
- Stage A (T1a or T1b) prostate cancer;
- papillary microcarcinoma of the thyroid, which for the purposes of the Policy means a papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid;
- noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0; and
- ductal carcinoma in situ (DCIS)of the breast.

Non-Life Threatening Cancer must be Diagnosed by a Specialist Physician with histopathological confirmation.

Exclusions:

Non-Life Threatening Cancer does not include any of the following:

- pre-malignant lesions;
- any carcinoma in situ except ductal carcinoma in-situ of the breast;
- evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

[No benefit will be payable for a recurrence or metastasis of an original Non-Life Threatening Cancer which was Diagnosed prior to the effective date of insurance.]

[*Non-Life Threatening Cancer Benefit Waiting Period:*

No benefit will be payable for Cancer and Non-Life Threatening Cancer and the Insured's insurance for Cancer and Non-Life Threatening Cancer will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the Insured's insurance; and
- the effective date of the Insured's insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of any cancer (covered or excluded under this insurance), regardless of when the Diagnosis is made; or
b. a Diagnosis of any cancer (covered or excluded under this insurance).

Although the Insured's insurance for Cancer or Non-Life Threatening Cancer terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Cancer or Non-Life Threatening Cancer or any Critical Illness caused by any cancer or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Non-Life Threatening Cancer Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Non-Life Threatening Cancer Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Non-Life Threatening Cancer Benefit Waiting Period.**]]**

[OTHER CONDITIONS CATEGORY

[Benign Brain Tumor means a confirmed Diagnosis of a non-malignant tumor located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumor must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumor must be made by a Specialist Physician.

Exclusions:
Benign Brain Tumor does not include pituitary adenomas less than 10 mm. in diameter.

[No benefit will be payable for a recurrence or metastasis of an original tumor which was diagnosed prior to the effective date of insurance.]

[*Benign Brain Tumor Benefit Waiting Period:*
No benefit will be payable for Benign Brain Tumor and the Insured's insurance for Benign Brain Tumor will terminate if, within [30 days] following the later of:

- the date we receive enrollment information for the person's insurance; and
- the effective date of the person's insurance,

the Insured has any of the following:
a. signs, symptoms or investigations, that lead to Diagnosis of Benign Brain Tumor (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of Benign Brain Tumor (covered or excluded under this insurance).

Although the Insured's insurance for Benign Brain Tumor terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Benign Brain Tumor or any Critical Illness caused by Benign Brain Tumor or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Benign Brain Tumor Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Benign Brain Tumor Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Benign Brain Tumor Benefit Waiting Period.**]]**

[**Coma** means a confirmed Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The Diagnosis of coma must be made by a Specialist Physician.

Exclusions:
Coma does not include any of the following:
- a medically induced coma; or
- a coma which results directly from alcohol or drug use.]

[**Major Organ Failure** means a confirmed Diagnosis by a Specialist Physician of the irreversible end-stage failure of bone marrow, kidney, liver or lung function, and:

- [for kidney failure only, dialysis (either hemo or peritoneal) is initiated;] or
- for all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Insured
  - is either listed with the United Network of Organ Sharing (UNOS); or
  - a suitable donor is found without a UNOS listing.

Proof of Major Organ Failure requires:

- submission of medical records documenting major organ failure from a Specialist Physician; and
- except for kidney failure on dialysis, documentation of either a
  - listing with the United Network of Organ Sharing (UNOS); or
  - documentation that a suitable donor has been found without a UNOS listing.

Major Organ Failure will be deemed to have occurred:

- [for kidney failure only, the date either dialysis is initiated,] or
- for all organs listed above, the date that the Insured
  - is either listed with the United Network of Organ Sharing (UNOS); or
  - a suitable donor is found without a UNOS listing.

Exclusions:
Major Organ Failure does not include any of the following:
- bone marrow failure that results from the treatment process for cancer;
- failure of any other organ not listed above; and
- autologous bone marrow transplant in which the Insured's own bone marrow is used.]

[**Paralysis** for the purposes of the Policy means total and irrecoverable loss of function of two or more limbs as a result of injury to or disease of the spinal cord. The loss must be present for a continuous period of at least [90 days] and be expected to be permanent. Limb is defined as the complete arm or the complete leg. The Diagnosis of paralysis must be made by a Specialist Physician.]

[**Severe Burns** means a confirmed Diagnosis of third-degree burns over at least 20% of the body surface. Severe Burns must occur while the Insured's insurance is in force to be eligible for a benefit. The Diagnosis of Severe Burns must be made by a Specialist Physician.]**]**

[CHILDHOOD CONDITIONS CATEGORY
The following covered childhood conditions apply only to children who meet the definition of Dependent Children and are insured under this Certificate:

[**Cerebral Palsy** means a confirmed Diagnosis of nonprogressive, neurological defect affecting muscle control. Diagnosis for Cerebral Palsy must be made by a Specialist Physician.]

[**Congenital Heart Disease** means a confirmed Diagnosis of at least one of the following covered heart conditions:

- coarctation of the aorta;
- Ebstein's anomaly;
- Eisenmenger syndrome;
- Tetralogy of Fallot;
- transposition of the great vessels; or
- any other congenital cardiac condition that requires life-saving surgery to survive.

It also means any one of the following specific conditions for which open heart surgery is performed to correct:

- aortic stenosis;
- atrial septal defect;
- discrete subvalvular aortic stenosis;
- pulmonary stenosis; or
- ventricular septal defect.

Exclusions:
Congenital Heart Disease does not include any of the following procedures:

- percutaneous atrial septal defect closure; or
- trans-catheter procedures which include balloon valvuloplasty.

The Diagnosis of Congenital Heart Disease must be made and the surgery must be recommended and performed by a Specialist Physician and supported by cardiac imaging acceptable to us.]

[**Cystic Fibrosis,** also known as mucoviscidosis, means the confirmed Diagnosis of a recessive genetic disease affecting most critically the lungs and also the pancreas, liver, and intestine. It is characterized by abnormal transport of chloride and sodium across the epithelium leading to thick viscous secretions. The Diagnosis of cystic fibrosis must be made by a Specialist Physician.]

[**Type 1 Diabetes Mellitus** means a confirmed Diagnosis where the Insured has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months. The Diagnosis of type 1 diabetes mellitus must be made by a Specialist Physician.]

[**Muscular Dystrophy** means a confirmed Diagnosis of one of a group of muscle diseases characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue. The confirmed Diagnosis of Muscular Dystrophy must be made by a Specialist Physician.]

[*Childhood Conditions Benefit Waiting Period:*
No benefit will be payable for any Childhood Condition and the Insured's insurance for such Childhood Condition will terminate if, within [30 days] following the effective date of the Dependent Child's insurance, the Dependent Child has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of such Childhood Condition (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of such Childhood Condition (covered or excluded under this insurance).

Although the Insured's insurance for such Childhood Condition terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within [6 months] of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for a Childhood Condition or any Critical Illness caused by a Childhood Condition or its Treatment.

The Childhood Conditions Benefit Waiting Period does not apply when newborn or newly adopted children are added to your Dependent Children Insurance.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Childhood Conditions Benefit Waiting Period.

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Childhood Conditions Benefit Waiting Period toward the satisfaction of the period of time required by this Certificate's Childhood Conditions Benefit Waiting Period.**]]**

[10.] LIMITATIONS AND EXCLUSIONS

What exclusions apply to the benefits payable?
In addition to the exclusions stated in the Covered Conditions section of this Certificate, we will not pay any benefit that is caused by, contributed to in any way, or resulting from any of the following:

- any Critical Illness condition Diagnosed outside the United States or Canada without confirmation of the Diagnosis by the type of Specialist Physician specified for each of the Covered Conditions in Section [9] who practices in the United States or Canada[; or
- any Critical Illness procedure performed outside the United States or Canada].

We will not pay a benefit for any Critical Illness that is due to or results from:

- intentionally self-inflicted injuries;
- elective plastic or cosmetic surgery;
- active military duty;
- participation in war, declared or undeclared, or any act of war;
- [active participation in a riot, rebellion or insurrection;]
- [committing or attempting to commit an assault, felony or other criminal act;]
- [engagement in dangerous conduct or hazardous activity where there is a likelihood of death or serious injury;]
- [being legally intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed; or]
- [improper or illegal use of inhalants or huffing].

What limitations apply to the benefits payable?
In addition to the limitations stated in the Covered Conditions section of this Certificate, we will not pay any benefit for any Critical Illness that is Diagnosed in the first [12 months] following the effective date of any Insured's insurance and results from a Pre-Existing Condition.

Pre-Existing Condition means during the [6 months] prior to any Insured's effective date of insurance, any condition for which any Insured:

- sought medical treatment, consultation, advice, care or services, including diagnostic measures for the condition, regardless of whether the condition was diagnosed or suspected at that time;
- took prescribed drugs or medicines for the condition[; or
- had symptoms for which an ordinarily prudent person would have consulted a health care provider for Diagnosis, care or Treatment].

We will apply any period of time satisfied under the Qualified Group Insurance Policy to meet the requirements of the Pre-Existing Condition limitation toward the satisfaction of the period of time required by this Certificate's Pre-Existing Condition limitation.

What are the maximum benefits payable under this Certificate?
[We will only pay one benefit for each Covered Condition shown in the Benefit Highlights.] We will not pay more than an aggregate of [100%] of the benefits payable for all Covered Conditions in the same Category as shown in the Benefit Highlights. [We will not pay more than an aggregate of [200%] of the benefits payable for all the Covered Conditions in all Categories shown in the Benefit Highlights.]

[11.] CLAIMS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us written Notice and Proof of claim within the time limits specified.

NOTICE OF CLAIM

When does written Notice of Claim have to be submitted?
Written notice of claim must be given to us no later than [60 days] after the date of Diagnosis or within [90 days] of the Treatment of the Critical Illness.

If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

When we receive written notice of claim, we will send the forms for Proof of claim. If the forms are not received within [15 days] after written notice of claim is sent, Proof of claim may be sent to us without waiting to receive the Proof of claim forms.

PROOF OF CLAIM

When does written Proof of claim have to be submitted?
Proof of claim must be given to us no later than [120 days] after the date of Diagnosis or Treatment of the Critical Illness.

If Proof cannot be given within these time limits, Proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time Proof is otherwise required unless the individual is legally incompetent.

What is considered Proof of claim?
Proof of claim must consist of at least the following information:

- a description of the Critical Illness;
- the date the Diagnosis and/or Treatment occurred; and
- the cause of the Critical Illness.

Proof of claim may include, but is not limited to, police accident reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials, as required.

We may require as part of the Proof, authorizations to obtain medical and non-medical information. Proof must be satisfactory to us.

PAYMENT OF BENEFITS

When are benefits payable?
Benefits are payable upon our receipt of satisfactory Proof of claim that establishes benefit eligibility according to the provisions of this Certificate.

When will a decision on your claim be made?
We will send you a written notice of our decision on your claim within a reasonable time after we receive the claim but not later than [45 days] after receipt of the claim. If we cannot make a decision within [45 days] after receiving your claim, we will request a [30-day] extension as permitted by U.S. Department of

Labor regulations. If we cannot render a decision within the extension period, we will request an additional [30-day] extension. Any request for extension will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have [45 days] to provide the specified information.

What if your claim is denied?
If we deny all or any part of your claim, you will receive a written notice of denial setting forth:

- the specific reason(s) for the denial;
- the specific Certificate provision(s) on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- [your right to bring a civil action under ERISA, §502(a) following an adverse determination on review.]
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

Can you request a review of a claim denial?
If all or part of your claim is denied, you may request in writing a review of the denial within [180 days] after receiving notice of denial.

You may submit written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

We will review the claim on receipt of the written request for review, and will notify you of our decision within a reasonable time but not later than [45 days] after the request has been received. If an extension of time is required to process the claim, we will notify you in writing of the special circumstances requiring the extension and the date by which we expect to make a determination on review. The extension cannot exceed a period of [45 days] from the end of the initial period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have at least [45 days] to provide the specified information.

What if your claim is denied on review?
If we deny all or any part of your claim on review, you will receive a written notice of denial setting forth:

- the specific reasons for the denial;
- the specific Certificate provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- [your right to bring a civil action under ERISA, §502(a);]

- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request;
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency."; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the appeal, regardless of whether the advice was relied upon to deny the appeal.

To whom are benefits payable?
We will pay you all benefits, if your Proof of claim is satisfactory to us, except in the following situations:

1. You are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons;
2. Due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described in item 1; or
3. You die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay to such person or persons.

If we do not pay you and claim is not made by the appropriate person designated above, we may, at our option, make payments under either or both Methods A or B below. Any decision to pay any benefits, prior to the appointment of the appropriate person designated in items [1, 2, or 3 above], is solely at our discretion, and we may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

Method A: We may pay up to the sum of [$5,000] to any individual or entity we determine has incurred or paid expenses as a result of funeral services provided to or on your behalf. If we pay such a benefit, we will not have to pay that benefit amount again and the total benefit due under this Certificate shall be reduced by the amount paid under this provision.

Method B: We may pay the whole or any part of such benefit:
- to your lawful spouse, up to a cumulative amount of [$5,000]; or
- if you have no lawful spouse, up to a cumulative amount of [$5,000] to any one or more of the following relatives in the following order of priority:

    1. your child or children; or
    2. your mother or father.

[12.] GENERAL PROVISIONS

ALTERATION

Who can alter this Certificate?
The only persons with the authority to alter or modify this Certificate or to waive any of its provisions are our president, actuary, secretary or one of our vice presidents and any such changes must be in writing.

[ASSIGNMENT

Can benefits be assigned?
You cannot assign any interest in this Certificate unless we agree in writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by us will discharge our liabilities under this Certificate, to the extent of such payments.]

CLERICAL ERROR

What happens when there is a clerical error in the administration of this Certificate**?**
Clerical errors in connection with this Certificate or delays in keeping records for this Certificate whether by us or the Policyholder:

- will not terminate insurance that would otherwise have been effective.
- will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error, subject to the "Limit of Premium Refunds" section.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of this Certificate conflicts with any applicable law, the provisions of this Certificate will be automatically amended to meet the minimum requirements of the law and to reflect updated statutory references.

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under this Certificate?
Payment made under the terms of this Certificate will, to the extent of such payment, release us from all further obligations under this Certificate. We will not be obligated to see to the application of such payment.

EXAMINATION

What are our examination rights?
We, at our own expense, have the right to have any person whose Critical Illness is the basis of a claim:

- examined by a Physician, Specialist Physician, other health professional or vocational expert of our choice; and/or

- interviewed by an authorized representative.

This right may be used as often as reasonably required.

INCONTESTABILITY

What is Incontestability?
Except for non-payment of premium, fraud, any claims incurred within two years of the effective date of an Insured's initial or reinstated insurance or as otherwise stated in this provision, we cannot contest the validity of such insurance regarding any Insured after it has been in force during the lifetime of such Insured for a period of two years from the Certificate Effective Date.

Additionally, for any insurance provided under the Policy that results from a statement of insurability submitted under the Qualifying Group Insurance Policy, except for any claims incurred before that insurance has been in force under the Qualifying Group Insurance Policy and this Policy for an aggregate period of two years during the insured's lifetime, measured from the effective date of the insurance for which the statement was provided, we cannot contest the validity of such insurance based on that statement.

This provision shall not preclude the assertion at any time of a defense to a claim based upon the Insured's eligibility for insurance.

INSURER'S AUTHORITY

What is our authority?
We have discretionary authority to make all final determinations regarding claims for benefits. This discretionary authority includes, but is not limited to, the determination of eligibility for benefits, based upon enrollment information provided by the policyholder of the Qualifying Group Insurance Policy, and the amount of any benefits due, and to construe the terms of the Policy.

Any decision made by us in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing our determinations shall uphold such determination unless the claimant proves that our determinations are arbitrary and capricious.

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of this Certificate?
If relevant facts about the Participant relating to this insurance are not accurate:

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the true facts will decide whether, and in what amount, and for what duration insurance is valid under this Certificate.

NON-PARTICIPATING

Does this Certificate participate in dividends?
This Certificate is non-participating and will not share in any profits or surplus earnings of Sun Life Assurance Company of Canada, and, therefore, no dividends are payable.

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?
No legal action may start:

- until [60 days] after Proof has been given; nor
- more than [3 years] after the time Proof of claim is required.

LIMIT OF PREMIUM REFUNDS

Is there a limit on premium refunds?
Whether premiums were paid in error or otherwise, we will refund only that part of the excess premium that was paid during the [12-month] period that preceded the date we learned of such overpayment.

NOTICE

How are required notices provided?
Any obligation we may have to give written notice will be satisfied by sending such notice to the last known address of the person or institution entitled to such notice.

PREMIUM PAYMENTS AS EVIDENCE OF INSURANCE

Does the payment of premiums guarantee coverage under the Policy?
The receipt of premiums by us is not a guarantee of insurance. Eligibility for benefits will be determined at the time of claim submission and all Policy requirements must be satisfied.

REIMBURSEMENT

What if a benefit is underpaid or overpaid?
Reimbursement will be made to us for any overpayments that we may make due to any reason. You must repay us within 60 days unless we agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If we have underpaid a benefit for any reason, we will make a lump sum payment for that amount.

Interest does not accrue on any underpaid or overpaid benefit unless required under the applicable law.

STATEMENTS

Are statements warranties?
In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by you in enrolling for insurance under the Policy will be used to reduce or deny a claim unless a copy of your written application for insurance is or has been given to you, your beneficiary, if any, or to your estate representative.

TIME PERIODS

What time periods apply to this Certificate?
For the purpose of effective dates and termination dates under this Certificate, all days begin at 12:00 midnight and end at 11:59:59 PM at the Participant's location.

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Critical Illness Insurance Certificate
[Critical Illness and Cancer]

Non-Participating